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ABSTRACT

The Student Health Projects (SHPs) were conceived more than 3 years ago by students in the health sciences as a primary step in their efforts to enhance the quality of their educational experience. The Chicago Student Health Project was devised, organized, and directed by members of the Student Health Organization. The format of this report is as follows: an introduction concerning the implications of the project for students; a background note discussing the implications of the summer's work for the Regional Medical Program; then an overview of some of the problems faced by the project is presented, dealing in depth with the black/white confrontation. The body of the report consists of two sections, the first composed of reports on the community sites where the students worked and the second an analysis of the work perfcrmed at a number of hospital sites. The final section presents a brief analysis of some selected characteristics of the participating students. (Author/PG)

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CHICAGO STUDENT HEALTH PROJECT summer 1968

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CHICAGO STUDENT HEALTH PROJECT
SUMMER 1968

Sponsored by

STUDENT HEALTH ORGANIZATION OF CHICAGO

and

PRESBYTERIAN-ST. LUKE'S HOSPITAL

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U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

Public Health Service

Health Services and Mental Health Administration

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PREFACE

The Chicago Student Health Project—Summer, 1968—was carried out under a contract with the Division of Regional Medical Programs (PH–43–68–1534) and was administered by the Section of Community Medicine of Presbyterian-St. Luke's Hospital. The faculty advisors were Dr. Adrian Ostfeld who, at the beginning of the Project, was Professor and Chairman of the Department of Preventive Medicine of the University of Illinois College of Medicine, and Dr. Joyce C. Lashof, Professor of Preventive Medicine, the University of Illinois, and director of the Section of Community Medicine of Presbyterian-St. Luke Hospital.

Explanation of the structure of the Project and preparation of the report is in order here. The Project was devised, organized and directed by members of the Student Health Organization. The student coordinating staff consisted of a project director, Lee Ballance, a third-year medical student at the University of Chicago Pritzker College of Medicine, and 12 coordinators. Each area coordinator was responsible for the selection of sites in the geographic area and for students located at these sites. In addition, there were coordinators responsible for the high school interns and the law students. The student staff was assisted by a research director, Mr. Philip Rushing, formerly administrative assistant at a junior college in Mississippi, who also had experience as a community organizer and youth worker in both Chicago and the rural South. He aided in the development of questionnaires which were used in some of the surveys undertaken by the students that will be reported in the following. He also served as an adviser and "troubleshooter" when problems arose. The preparation of this final report has been primarily the responsibility of Mrs. Irene Turner, Research Associate in the Section of Community Medicine.

All students submitted site reports, research reports or personal essays at the completion of their assignments. All of these have been read; some are reproduced here in their entirety, others have been quoted and some abstracted for this text. Due to the lack of space some student's reports have not been included.

The format of this report is as follows: There is an introduction written by Mr. Lambert King, a fifth-year M.D.-Ph.D. candidate at the University of Chicago's Pritzker College of Medicine and chairman of the Chicago chapter of the Student Health Organization. It concerns the implications of the project for the students. Mr. Lee Ballance, the project coordinator, has written a statement giving background information and discussing the implications of the summer's work for the Regional Medical Programs. Mr. Philip Rushing, research director, has described his overview of some of the problems faced by the project, dealing in depth with the black-white confrontation.

The body of the report consists of two sections, the first composed of reports on the community sites where the students worked and the second an analysis of the work performed at a number of hospital sites. Mrs. Ann Prosten, a member of the Section of Community Medicine, assisted in the preparation of the Community Sites Section.

The final section presents a brief analysis of some selected characteristics of the participating students and was prepared by Mrs. Turner.

The report of each student represents the work and thinking of that student alone, and its publication here indicates neither approval, or disapproval of any other individuals, institutions or other students.

A final editorial word: I hope that when the students read this final report they will realize that they accomplished more than many of them thought they had. They have indicated how much they learned and profited from their summer's experience in their reports. I offer them my congratulations.

JOYCE C. LASHOF, M.D.
Director, Section of Community Medicine.

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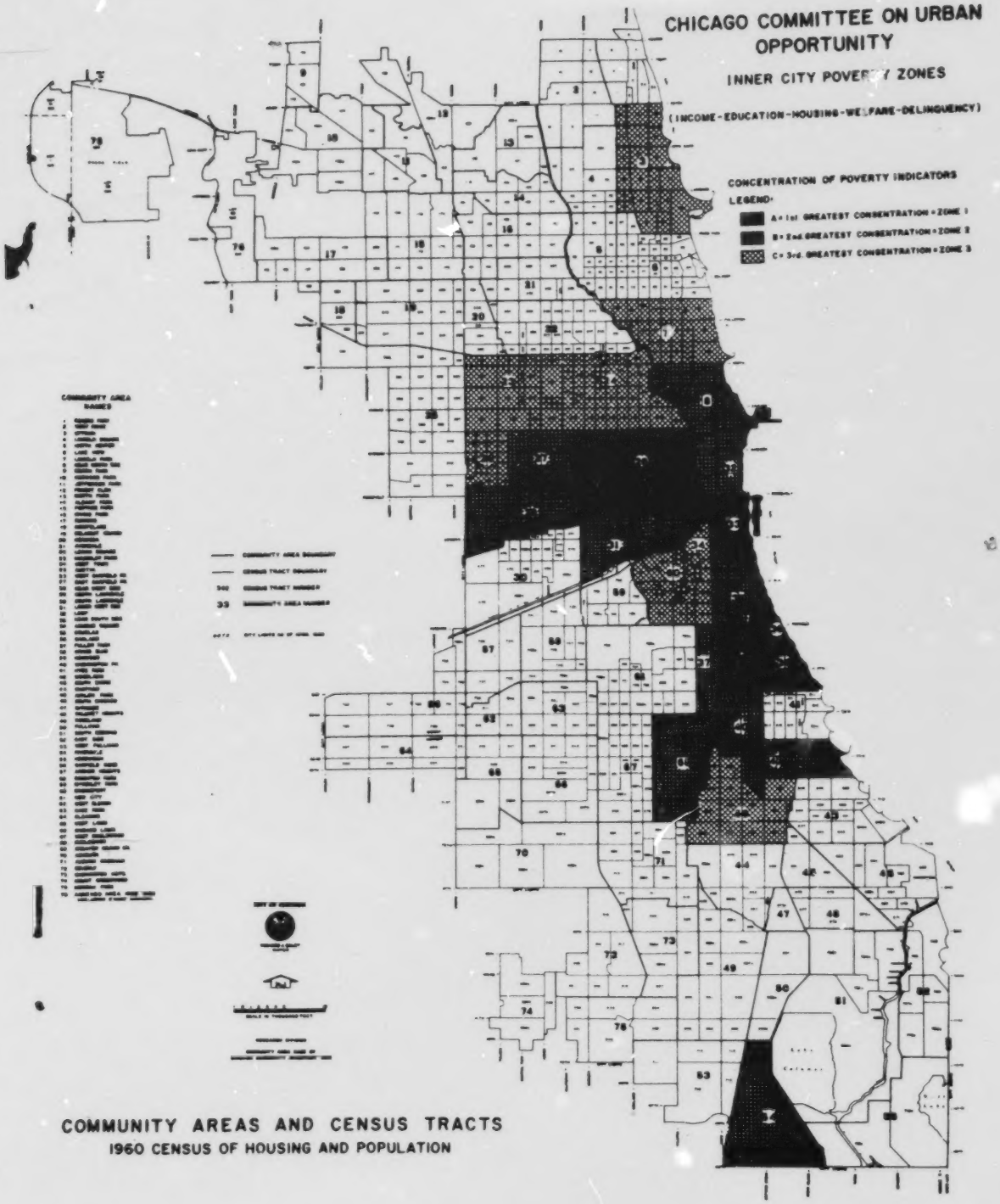
CHICAGO COMMITTEE ON URBAN OPPORTUNITY
INNER CITY POVERTY ZONES
(INCOME-EDUCATION-HOUSING-WELFARE-DELINQUENCY)
CONCENTRATION OF POVERTY INDICATORS
LEGEND:
A = 1st GREATEST CONSENTRATION = ZONE 1
B = 2nd GREATEST CONSENTRATION = ZONE 2
C = 3rd GREATEST CONSENTRATION = ZONE 3
COMMUNITY AREA NAMES

COMMUNITY AREAS AND CENSUS TRACTS
1960 CENSUS OF HOUSING AND POPULATION

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Section I. INTRODUCTION

The Health Science Student Experience on the 1968 Chicago Student Health Project

by Lambert King (Medicine)

The Student Health Projects (SHPs) were conceived more than 3 years ago by students in the health sciences as a primary step in their efforts to enhance the quality of their educational experience. Initiated and designed by Student Health Organization members and cosponsored by leading medical schools and health care institutions, 12 major Student Health Projects have taken place—one in 1966, three in 1967, and eight in the summer of 1968. The burgeoning growth and the striking results of these projects have been unprecedented in health professions education in the United States. The energy, momentum, and creativity necessary to mount these projects are indicative of major change in the goals and attitudes of a broad sector of contemporary health professions students. An analysis of the experience of the hundreds of students across the country who have participated in these projects is likely to yield implications of vital importance for the future of health science education and health care.

The Student Health Projects are best considered as an integral component of the more general student health movement that has initiated the SHPs. Within only 3 years the attitudes and goals of the students involved in organizing these projects have undergone a distinct evolution. The socio-political-psychological evolution of the students participating in the projects reflects their response to a complex array of societal-wide issues and conditions. Indeed the very flexibility of their response to the problems they have confronted is indicative of a capacity for self reappraisal that is a salient change in the social orientation of health professions students.

The implications of the 1968 Student Health Project in Chicago should be analyzed first for the central similarities of the 1968 student experience as compared with the experience of students on SHPs during the 2 preceeding years; the commonality of the goals and responses of the students to their experience in all of the projects during the past 3 years reflects some of the most consistent and important qualities of the new generation of health students. But proceeding beyond the areas of similarity in the past and more recent projects, one should also examine the distinct evolution that has occurred in the attitudes of each succeeding group of student project participants. It is in the evolution of the student experience that the most important trends for the future may be found and directed toward other health science students, teachers and administrations of health professions schools, and the other organized representatives of the health professions. The implications of the experience of these deeply committed progressive health science students must be heard and acted upon with a constructive spirit of renewal and reform.

During the past 3 years health professions students have been the prime initiators of the Student Health Projects; they have recruited fellow students, negotiated for substantial funding, and have determined the location and nature of their own project experiences.

> The third distinguishing characteristic of our program involved a large amount of autonomy permitted—encouraged—in the

> student participants. This intentional minimization of its structure was intended to permit students to exercise their own initiative in identifying and pursuing activities in potentially fruitful areas within the broad context of their own particular summer placements * * * (*1*)

Generally the quality of student leadership which has initiated and organized the SHPs has provided a convincing demonstration of student capability and creativity in determining the nature of a sizeable segment of their educational experience. In the case of the Student Health Projects, this experience has centered around the focus of action and research-oriented multidisciplinary community health programs. Each of the projects has brought students together for a previously unavailable interaction between students of all health disciplines, community workers, community organizations, and established health agencies. The impact of this somewhat loosely structured yet uniquely challenging experience for most of the students involved has led many of the student participants to compare the project experience with their own conceptual model of a "free university of health."

Throughout the 3 first years of the Student Health Projects, student participants have concluded that the projects have demonstrated that the health professions students themselves are far more capable of determining the nature of their own educational process than the present organization and structure of their schools permits.

> As students we have no voice in determining our educational process. Except for a minimal amount of time devoted to a narrow range of electives, we are not allowed to plan our courses; nor are we allowed to judge our professors or examine the qualifications for admission or promotion of our peers. In each of these functions the student has as much at stake as faculty personnel to promote the excellence of the university. Both faculty and students are subject to similar errors of judgment.

> We focus around community health because we are dismayed at the retreat of the health professions schools from contact with the clients of our professions. We are concerned not only with the basic science view of health, illness, and therapy; we are outraged by the lack of education in the area of socio-economic determinants of health and disease. * * * (*2*)

Students foresaw two major goals for the participants; personal experience on the projects as distinguished from the equally important results of the students' work. First the projects were intended to result in basic changes in the sociopolitical viewpoints and attitudes of the largely middle and upper middle class student participants. Second it was intended that the body of student participants would in the coming years constitute an experienced and united corps of young health professionals dedicated to reform of the United States health care system.

> Perhaps the problem of changing society is insoluble, but after one summer of immersion in the frustration of the South Bronx, I believe realities must be challenged and changed, hopefully with the cooperation of the full resources of our society. For the cancers that infect our society, only radical change offers any hope * * *.

> My summer's experience leads me to conclude that students must create a new health profession concerned with the real problems of society. An organization which responds to the needs of the people and which rationally utilizes and provides for health manpower is needed.* * * We have not changed the places we worked in this summer, nor was it realistic to think that we would. But we have changed ourselves—our aspirations, actions, our beliefs. In this departure from the lack of involvement with social problems shown by the past genera-

> tion of health students lies the catalyst for making our dream of a vibrant American health profession a reality.* * * (3)

Consistently the student participants on this year's and on previous Student Health Projects have viewed their project experience as bridging an all important gap in their formal health science education. This experience has led them to verbally and organizationally commit themselves to life styles and career orientations centered about contemporary biosocial issues.

> I have looked and, perhaps I have found. I have been a member of the Student Health Project, I have met people who made my former "liberal views" pale by comparison * * * Most of all, I have been given the opportunity to spend 10 weeks during my years of medical training thinking about riots and open housing and the welfare system as medically and socially significant entities which directly pertain to me and for which I must attempt a solution. (4)

Following the 1967 Student Health Projects, both the Student Health Organization of Chicago and other Student Health Organization groups across the country began to seriously examine the larger issues confronting them as a result of their 2 prior years of involvement in the community and in the development of their own projects. Health science student activists articulated a challenging conception of the obligations of health professionals. Their broader definition of their own future role led them to confront issues and problems that deeply affected the reform of health care and health science education.

> The defining purpose of the Student Health Organization is the achievement of human welfare, good health in a total sense. A commitment to human welfare must lead to concern with relevant political affairs. We consider the involvement of the people in the United States in the war in Vietnam to be inimical to human welfare in its sacrifice of life and disruption of culture for the sake of unjustifiable military and political priorities. (5)

At the inception of the 1968 Student Health Projects, many of the student participants felt that such statements as the preceeding one were highly relevant to the goals of reform-minded and progressive health science students. Indeed the writing of the student participants on the 1968 Chicago project reflect a more sophisticated and well-documented understanding of such socially critical subjects as Black Power, war and the health profession, political dissent in medicine, and consumer control of health care planning.

The 1968 Student Health Projects witnessed a widespread conclusion among student participants that the focus of their work must be broadened to include not only direct action in poverty communities but to encompass reformation within their own schools and health care institutions. Many students on the Chicago project felt that their experience in black communities striving to develop their own leadership was detrimental to the eventual solution of problems of such relatively powerless communities. The students' study and analysis of the shortcomings of health care in ghetto areas often lead them to conclude that the prime cause of this poor health care lies not in the black community but in the lack of significant commitment on the part of powerful institutions, schools and government agencies to the solution of these problems. Seven students who worked attempting to set up an evening medical clinic in the Robert Taylor Homes area on the 1968 Student Health Project concluded.

> * * * This student venture may be instrumental in adding another incident in a long series of disappointments, as well as acting as a channel to divert energy from places where it may be more effectively placed. Fortunately, through a combination of coincidences, the Taylor project is at least functioning. Students do not need to organize in poor communities—Appalachian white, Spanish or Black—to learn about the problems that affect

> the poor. Middle class whites are foreigners to the poor and always will be. Contact with middle class whites, SHOs own constituency, can teach the same classic lessons.

The student participants on the 1968 Chicago SHP involved themselves deeply in the most difficult problems and issues underlying what has come to be known euphemistically as the crisis in health care delivery. For most of the student participants, their experience was of crucial importance—it was an experience that their own schools were either unwilling or unable to provide. A brief 10 week's immersion in the milieu of poverty led some students to conclude that the "crisis in health care delivery" had deep and intimate roots in the policies and attitudes of health schools, health care institutions, and more broadly, in affluent, white America. As students, they concluded that they must concentrate upon obtaining more freedom in their schools to redesign and broaden the nature of their educational experience; as future health professionals, they concluded that they must work to bring change within health care system under the control of the impoverished communities that have been most decimated by the lack of a humane, rational health care.

The report which follows contains not only a description of the work of the students, their findings and impressions but gives clear evidence in their personal essays that they are moving toward nothing less than a long term commitment to a new health profession based upon both science and social justice.

Background Information and Implication for Regional Medical Programs

by Lee Ballance (Medicine)

The 1968 Student Health Project was funded by the Division of Regional Medical Programs of the Health Services and Mental Health Administration of the Department of Health, Education, and Welfare. It is important that all parties concerned take some time out to look at what has been learned from the summer's experience. First it is important to note that by giving 124 students from various health science fields the opportunity to work in and with community groups towards solution of community health problems, the project and its sponsors contributed to the growing pool of interested, aware, and vitally concerned students dedicated to the solution of America's health problems. It afforded 75 high school student "interns" the opportunity to work within their own communities towards solution of their own problems. The project also gave one intern the motivation to become a doctor, another the insight that the solutions to his community's problems lie largely within that community itself, and a good many the faith that things can be changed for the better. These immeasureable contributions are probably the most important result of the summer's experience, but the RMP's also gained the not insignificant reports which make up the bulk of this volume. Some of these report events and insights which we think others should share. Others contain the results of the numerous and diverse research projects carried out by the intern-student teams last summer.

In introducing this volume, no attempt will be made to force its contents into a series of neat generalizations. In putting it together out of the multitude of reports, questionnaires, and other documents which were left at the end of the summer, an attempt has been made to leave the summer's story in the words of the students who experienced it. It would be insulting for anyone to try to tell the reader what it all means. Rather the reader is left to read the book through and find in it his own meaning. This introduction will serve only to provide some background information which should be helpful in tying things together.

The planners of Student Health Projects have been troubled since the beginning with the dichotomy between education and service. It soon became clear that the goal which could be most regularly and satisfactorily attained and quantitated was that of education of the student participants. It was equally clear that using the medically deprived community as a summer teaching laboratory without providing a fair amount of service to that community ranked with the worst forms of exploitation. It was the thesis of the planners of this project that one could learn a great deal without providing a bit of service, but that one could not make a serious attempt at serving the community without learning a lot as a result.

But what kind of meaningful service can a group of nursing, preclinical medical, law, social work, and high school students provide in 9 weeks time? This was a question which could only be answered by the community organizations and groups with which the student teams would work. In order for any community-oriented project to be maximally effective in defining and attaining its goals, it must be conceived and planned with the full cooperation of all people directly affected by it. For this reason much of our energies during the planning stage of the project were devoted to discussions with the members and leaders of the communities in which students were to work. Thus the individual site-projects evolved over the winter and spring.

Some students were assigned to doing community health resources surveys and drug price surveys which the community groups could use to help their constituents get better health care. Other students found themselves working with the two community-sponsored clinics which grew out of last year's project. Still others found themselves working on housing, urban renewal, and lead poisoning prob-

lems which, while not strictly medical, were considered essential to the health of the community.

On a different level, many students worked on more conventional research projects. The focus for most of these was the attempt to understand the current health care system of the city of Chicago. The majority of these projects took place in various hospitals and out-patient clinics in the city.

Yet, as will rapidly become clear to the reader, the focus of the reports from these diverse placements is confrontation: confrontation between health science student and intern, between community members and project workers, between students and politicians, between students and staff, between old concepts and ideas and new ones. It seems as if no one went through the summer without having at least one of his actions or ideas seriously challenged. Our research director, Rev. Philip Rushing, has analyzed the reasons for many of these confrontations in an accompanying paper. It seems also that these challenges were a significant part of the summer for most of the students. Reading their detailed reports, one can gain a great appreciation for many of the major issues which confront anyone who tries to work with the community in solving its health problems. The reports are also a valuable record of success and failure in attempting to meet these challenges.

With this as a background let me next discuss the implications for RMP as I see them.

RMP is not involved in the actual provision of medical care. Further, they are prohibited from "changing the existing organization of medical care"—a somewhat ambiguous provision since RMP's very existence changes the organization of medical care. The major premise, as well as the initial impetus for RMP's inception, is their potential to raise the health status of American communities by regional planning and regional problem-solving. The best method of attaining this goal, is to work with and through community groups who have similar interests, i.e., improving the health conditions of the community. This is not simple —as the students learned this summer—but while it may be difficult it is most rewarding.

The concept of regional *medical* programs appears to be a limited one. More appropriately the concept should be that of regional *health* programs. The word, *medical*, implies 'curing' or 'caring for' when actually RMP must concern itself with the health of a region not the medicine or medical care provided in that region.

This might mean that elimination of air pollution, implicated in the etiology of lung cancer, may well be as important as sophisticated research into its chemotherapy or building and equipping intensive care units for post-pneumonectomy patients. Resolution of the social stresses, implicated in hypertension, may be as important and economical as designing computerized link-ups of cardiac care units.

The goal of prevention of disease must become as important as the goal of curing disease. If RMP is to be concerned with such approaches, then community involvement at every level in its various programs is essential. RMP can help a community achieve power and importance by allowing the community to make its own decisions, or be involved in decision making, on its own terms. By doing so, it can create a climate in which many problems central to the total health needs of the community can be solved. RMP can become a catalyst in the process of social change rather than another organization in a plethora of organizations planning a surfeit of programs—most of which will have no lasting impact on the health of whole segments of the population.

These broad definitions of the appropriate role of RMP may be very difficult of acceptance, let alone achievement. Perhaps, change is indicated in RMP's enacting legislation to permit it to broaden its approaches and deal with very real health problems involving whole communities.

It is probably easier for students to embrace these approaches than it may be for RMP planners. Students have little or no vested interest in defending the present medical care

system since it is not "ours" yet. But RMP planners are part of that medical care system. It is "theirs." Students are prepared to be, and indeed are, highly critical of that system, but criticisms of that system by members of the Establishment—as are most people in control of local RMP's—is less likely to be forthcoming. Students are without power. The medical school deans, hospital administrators, and medical society representatives who administer local RMP planning have a substantial amount of power. Resisting the temptation to wield this power as a club over the heads of consumer and community groups will not be easy. People in control of local RMPs will have to guard against their own, quite natural, tendency to defend and enlarge their own "empires." They will need to sublimate their own needs for power and prestige to the total health needs of the community and to the need for social change. Therefore for local RMPs to come to grips with some of the new and changing scene will not be as easy as it was for the students—although it was not easy for them either.

However, the demands of community groups for the right to govern their own lives will continue to escalate. This is attested to by the increasing demand for community control by such disparate groups as the Black Panthers, the Dissident Democrats and the American Independence Party and also by the increasingly common provisions for consumer and community control in Federal legislation. RMP will, as will many other American organizations, need to hear these demands and bring creativity and inventiveness to meet the challenge they offer. The students heard them and have been profoundly influenced by them. This will be evident as their reports in this volume are read. We hope that these experiences will be of value in offering RMP new insights and avenues through which it can more effectively fulfill its promise.

The Black-White Confrontation

by Philip Rushing

The project encountered several problems that caused some degrees of frustration for almost all of the students. First, many students were perturbed by the ambiguity of their roles and complained that they did not know exactly what to do. Part of this uncertainty was due to the deliberate attempt of the staff to avoid stifling students' creativity by a strict guidelining of their roles, thinking the summer's experience would be more productive were students independent to design their own activities. However, the students "syndrome" of having functioned more or less within a prescribed framework and of having their work procedures defined for them probably played a part.

Second, organizational logistics—many students complained about poor communication between themselves and staff. This situation was the result of the wide area over which the project extended and the inconvenience of not having ready access to a telephone. The project was officed in Presbyterian-St. Luke's Hospital on a new floor of an unfinished building and was without telephone service (due to the Brotherhood of Electrical Worker's strike). Office personnel had to go from the 10th floor of this building to the third floor of an adjacent building to make calls. This situation not only limited staff-student communication but also impeded effective coordination and administration of the project's activities.

Third, the attitudinal confrontation between the health science students and the black high school interns—initially, some students had difficulty relating to their interns. Different attitudes, value patterns, and goal objectives created a communication and social barrier between student and intern. Both brought to the project preconceived expectations and were annoyed when those expectations were not fulfilled. Students expected mature behavior from the interns while the interns expected an understanding "big-brother" type of behavior from students. Analytically, this confrontation was a valuable experience for both student and intern. Both realized the difficulty involved in learning to relate to people who are ethnically and culturally different. Both seemed to realize that by working together for a common concern a meaningful affinity can develop between people in spite of their differences. At the close of the project, relations between students and interns were decisively improved. Between some at the wrap-up conference, there were indications that this would continue. Addresses were being exchanged, interns were leaving each other to sit and dine with students and vice versa.

Though these problems had some significance, the overriding problem throughout the summer was that of the black-white confrontation. The effect upon the students stands out in almost all the individual essays, as will be seen in the reports that follow. The essence of the problem was poignantly described by one student as follows:

> Into the church where we worked walked Black Power. They told us in no uncertain terms that we were unwelcome in their "hood" and that we should leave immediately. A concensus of white opinion was taken and it was our most "noble" hour when it was conditionally decided that we would stay, at least until we had found out who the youths were, and whom they represented. In a few days following the incident, our physical stake was pulled and we left the neighborhood. My emotional stake remained, however, and I continued throughout the summer to work for the Clinic.
>
> I worked because I wanted to see a lot of work come to fruition, and I worked because I didn't want frustration and finally despair to overcome the indigenous committee of women

who had been with this project from the beginning. What was wrong with all of this?

First, I, and probably many others, assumed our jobs without a real understanding of the past relationship between the white and black people in the area. Of course we know things were bad and could spout words like white racism and neo-colonialism but I, for one, didn't really understand how these phrases could apply to our well-meaning effort. I didn't realize until a few weeks after the beginning of the project that all our efforts at organizing the community were impeded by the belief of many that the Student Health Project was just another extension of the mistrusted University of Chicago. Also, I didn't know that because many other white liberals had come into the area before us and had changed nothing, we were judged either guilty or impotent by association. And lastly, I didn't realize until much later that what I thought was our greatest asset—our organizational skills and abilities—was one of our greatest liabilities. (Stephen P. Rand.)

Militants precipitated situations that created a constant problem for students and at times threatened to submerge the project's achievements. Articulate, sometimes raw, and often provocative young militants spewed their rhetoric as they evinced their position, stressing their determination to organize their own communities, accusing some students of being tools of the "Establishment" dispatched to safeguard the Establishment's "colonial" interest, and challenging white students "go organize your own community and leave ours to us." On the premise that liberalism perpetuated rather than solved ghetto problems, Black Power rejected it, maintaining that effective solution must be built into black ownership and control of ghetto institutions.

In addition to presenting some very serious problems, the black-white confrontation enhanced the summer's learning experience. This learning occurred on two levels—individual and community.

1. The individual level—The militants' position provoked students to really see, hear and feel the pathos, dynamics and mentality of ghetto life for the first time. In contradistinction to Negro passivity of previous decades, disciplined to deceive white liberals in order to incur paternalism, black militancy "told it like it was." Initially shocked by this raw militancy, students began to probe their own motives and intensified the on-going debate on the moral right of white students to interject themselves in the life of ghetto communities at a time when these communities were struggling for *esprit de corps*. This direct personal encounter with militant segments of ghetto leadership, the introspection it precipitated, enlarged students' understanding of ghetto problems, increased their appreciation for poor black people and inspired students to a creative search for a redefinition of their role as health professionals seeking change in a health system that is not responding to the health needs of the poor.

2. Community level—That the ghetto is undergoing radical ideological and organizational transformation was readily observed by students. New attitudes are forming and new manhood is developing as the influence of Negro passivity is waning while that of black militancy is increasing. The emerging black man is unwilling docilely to accept roles prescribed for him and is resolute in his commitment to master his right to self-determination. Consequently, militants are moving for control of ghetto institutions and the Negro power structures and they rationalize their activity on the premise that these structures are mere extensions of the "system" and are therefore illegitimate. Concluding whites are the true owners of Negro power, and reasoning that out of self-interest whites support and perpetuate a Negro elite, these blacks want whites out. "Get out, Whitey, and leave the driving to us," was the cry often heard by white students.

Currently, the Black Power confrontation is basically a conflict between powerless young

militants and old line conservative Negroes who occupy positions of power. These militants are dissatisfied with the way the affairs of their community are being conducted, and are pressing for change. Militants hold whites responsible for the conflicts, thinking whites by means of liberalism deliberately keep the black community divided. Not having a constructive strategy for achieving their goal, young militants roam their community seething with discontent. Like a powder keg, they can be set off with the slightest provocation. Provocations are often provided in the form of exploitative business practices, excessive police forces or whites controlling ghetto institutions. Militants feel black unity is a first priority to solving ghetto problems and ridding the community of whites would facilitate this unity and thus control of community. Militants really want power over their lives to control their community, to rebuild it, to withdraw into it as they attempt to escape the frustration and complexity of an engulfing society. They want a place for blacks to develop their resources and "peoplehood" competent to function on a level equalling other ethnic groups. Lacking the means to achieve this within the context of the "system" drives them to struggle for it outside the system. Sometimes impetuous and often unseasoned, they maneuver without careful design, often alienating would-be supporters and incurring repressive measures for both themselves and their community.

3. Students' assessment of the black-white confrontation—In their assessment of the confrontation, students tended to be overly critical of themselves. Three influences probably underlie this tendency to demean their personal effectiveness:

(*a*) Solution to ghetto problems per se was not an overriding consideration underpinning student liberalism and desire for change. This is not to imply that students were not seriously concerned about the plight of poor blacks. They were, but only as the blacks' problem was a syndrome of a much larger problem. It is at this level students and militants part. Militants are committed to the rectification of ghetto ills to the exclusion of other considerations; students are committed to a rectification of the ills of the total society.

(*b*) Students' inclination to underrate their own effectiveness was probably a rationalization of an emotional "hangup" that inhibited their capacity to grapple "head on" with the challenge presented by the confrontation.

(*c*) Students tendency to devalue their community contribution was probably influenced by unresolved feelings of paternalism—students felt the need to measure success and help in terms of "doing something for poor people" to the exclusion of "being something to poor people." It was difficult for students to understand that "just being there" (emotionally as well as physically) had positive value.

Finally, solutions to ghetto problems require the participation of student health projects. These projects bring to the community a sense of dedication and expertise desperately needed. However, future involvement in ghetto areas must consider the historical frustrations and disappointments sustained by ghetto people at the hands of well-meaning liberals.

REFERENCES

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(*2*) Peter Schnall, Lew Rosenbaum in Encounter, the Bulletin of the Student Health Organizations, Summer, 1967.

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(*4*) Claire Wittenmeier, Report of the 1967 Chicago Student Health Project.

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Section II. COMMUNITY SITE REPORTS

More than half of the over 40 sites where summer of '68 Student Health Project teams were assigned can be defined broadly as community organizations. These are the settlement houses or special project centers sponsored by neighborhood churches, private agencies, or indigenous self-supporting community associations. Many of these have come into being in an effort to cope with community needs which society, or the appropriate government agency, may occasionally acknowledge, but which are not met with the requisite facilities, funds and personnel, nor with programs and policies necessary to assure their effective utilization.

Several sites were community health clinics, in some cases established and functioning partially as a result of student health project participation, or where the students acted as catalysts enabling the community to establish such clinics. Common to all the community sites to which SHP teams were assigned was the community's unmet needs for accessible, quality health care and education.

In some instances, the teams continued work begun by their predecessors during the summer of 1967. In every assignment the work was health oriented, if not directly health focused. The projects were defined through joint site-sponsor, SHP discussion and the execution of the project was subject to the guidance of the sponsoring group.

This section summarizes the SHP community experiences as the students and interns reported them. In some cases the students' essays will constitute the entire report on the site; in others, a precis of their experiences with quotations from their reports will be the mode of description. A number of reports and commentaries are reprinted in full for the quality of work and thought which they reflect.

The presentation is in general geographic sequence; from the Uptown community bordered by Bryn Mawr Avenue (5600 north), to the Southwest area at Trumbull Park (105th Street South).

THE NORTH SIDE

Uptown

The area: A strip that runs from 4000 North (Irving Park Road) to 5600 North (Bryn Mawr Avenue) and from Lake Michigan on the East (about 400 West at that point) to beyond Clark Street (about 1600 west at this location). It is a portion of Community Area 3.

The population: A mixture of Appalachian whites, American Indians, Spanish-speaking Americans, these groups are mainly recent inmigrants; a Japanese population which has been there since the end of World War II; a few blocks of predominantly black population; and a substantial number of mostly single, indigent, elderly white people, many of whom have been located in Uptown by social service departments of mental and chronic disease institutions. In 1964, the estimated white population of the whole of Community Area 3 was 93,000, while the nonwhite population was estimated to be 2,225 (2.4 percent). (*1*)

The only data available as to income and housing is based on 1960 census tabulations and the area has changed since then with more poor people moving in. However, even at that time the percentage of families with incomes below $3,000 per year ranged from 16.6 percent to 30.1 percent in seven out of the 21 census tracts in the area. In these same tracts the percentage of substandard housing ranged from 25 percent to 60.5 percent with only one having lower than 23 percent poor housing. (*2*)

Uptown is ranked as a zone 3 poverty area (the third greatest concentration of poverty in the 24 poverty zones as determined by the Chicago Committee on Urban Opportunity). In

ranking five mortality and morbidity factors, the section of Uptown in which the students worked ranks in the 2d (highest) quartile for numbers of deaths due to influenza and pneumonia both for infants and noninfants; it is in the 2d quartile for deaths due to cervical cancer and 2d also for new cases of tuberculosis; it is in the first quartile (the highest) for deaths due to unknown and ill defined causes. (The diagnosis, "ill defined causes" on a death certificate frequently reflects the extent or lack of medical care precceding death.) (*1*).

SHP teams operated at three Uptown sites: The American Indian Center; the Tri-Faith Employment Service; and United People, a neighborhood organization concerned with the impact of urban renewal in their area.

Medical student James Drake, working in the American Indian Center team, describes Uptown in these words:

> The Uptown area of Chicago boasts fine apartment buildings just off the [lake] shore, modern hospitals scattered throughout, and thriving businesses on all the major streets. One's first impression is that this must be a progressive and promising part of Chicago; in fact, a fine place to begin a career, invest in a business—even rear a family. But it doesn't take a sharp observer too long to see Uptown's more typical streets and discover its "other face": the face of poverty, slum housing high density living, dirt, disease and ignorance. As one finds street after street in the same deteriorated condition, one begins to realize that this is indeed an area with grave urban problems.

The 'other face' of Uptown, is described in greater detail by Lynnae King, SHP coordinator for the area. Her report is printed in its entirety.

Health science students and interns, at both the American Indian Center and at the Tri-Faith Employment Service sites, undertook surveys of health needs and facilities and completed a comparative study of drug prices which had been started by SHP teams the previous summer.

The teams followed up the surveys with "test" projects, introducing residents to local clinical resources. They also participated in screening children from the Indian community for a lead poisoning detection program conducted jointly with the Montrose Urban Progress Center.

The American Indian Center team notes among its accomplishments:

> The health survey will leave a permanent record for use by the Center and other concerned agencies, including the Commission on Health Planning and Model Cities. It was impossible to determine the adequacy of health care for the American Indians from previous studies, since the Indians were never considered as a distinct ethnic group.

There were 133 personal interviews in the survey, yielding information for 620 individuals. The essay, "Indian Summer" describes one such interview, and a more detailed report on the over-all survey will be found in the report, "Health Care in the Indian Community".

Some of the specific accomplishments of the American Indian Center team of students included:

- Preparation of a two-fold plan, adopted by the Montrose Urban Progress Center, for the treatment and prevention of lead poisoning, now a widespread phenomenon among Uptown children:
- Establishment of a North Side Treatment Center at the Montrose Urban Progress Center. (Children have had to go to the Municipal Contagious Diseases Hospital on the southwest side of the City—a considerable distance).
- Creation of a central file at the Montrose Center which lists dangerous buildings where lead poisoning cases have been identified, and distribution of this list to the community and to the renting agencies.

This team's survey of drug prices in Uptown discovered some interesting pricing practices

in the 14 drug stores involved. For at least one of the prescriptions tested, 12 of the 14 drug stores charged Indians higher prices for the item than they did non-Indians. The variation in prices between drug stores however indicate that all residents of the area are victimized to some degree by the pricing practices of the surveyed stores.

Description and results of the survey follow.

As members of the Student Health Project, we have been working this summer in the Uptown area. Our sponsor, the American Indian Center, knows of all our activities; and with its consent, we have undertaken a drugstore survey. From the results of this project, we have compiled information which we wish to relay, in the hope that you will save both time and money.

The drug survey was conducted by six people, three Indians and three non-Indians. Six prescriptions were obtained from reputable doctors in the Chicago area. The six individuals involved in the price survey proceeded separately from one drugstore to another, asking the charge for filling each prescription.

Many factors could have influenced the results of the survey. One possible variable is that the pharmacists may have realized what the purpose of our investigation was, after being asked to quote prices to six individuals on six different occasions. In addition, different pharmacists may have misquoted prices from memory, but would have checked more accurately if the investigators had paid at that moment. However, in analyzing our results, we have made the necessary assumption that all the prices quoted were given in good faith, with the expectation that the investigators really intended to buy the drugs.

There were 14 drugstores in Uptown where the six investigators brought their prescriptions at separate times and requested information from each store as to the cost of filling the prescriptions. There was a wide variance in costs for each of the prescriptions both between prices charged Indians and non-Indians and between prices of the different stores. The following are the data relative to differences in costs to the Indian and non-Indian investigators.

		Number of drugstores in Uptown		
Prescription	*Total*	*Charging more to Indians*	*Charging the same to Indians and non-Indians*	*Charging more to non-Indians*
Penicillin	14	5	5	4
Chlor-Trimeton	14	12	0	2
Ortho-Novum	8	2	4	2

The increase in prices for penicillin ranged from 4 percent to 100 percent more charged Indians as compared with non-Indians in the five stores where this occurred. The price variations were even greater for filling the Chlor-Trimeton prescription. Indians paid from 1 percent to 195 percent more than non-Indians. Only one store had the low price differential of 1 percent. Eight of the 12 stores charging Indians higher prices for this drug charged from 30 to 195 percent more. The two stores charging Indians more for Ortho-Novum charged them 12.5 percent and 66 percent more respectively.

There was also a wide difference in prices charged between the different drugstores for all three prescriptions, as follows:

	Cost of filling penicillin prescriptions		
Number of stores	*To Indians*	*Number of stores*	*To non-Indians*
1	$2.40	2	$2.50
1	2.50	5	3.00
5	3.00	4	3.50
1	3.50	1	4.00
1	3.65	2	6.00
2	4.00	---	----
1	4.95	---	----
2	5.00	---	----

The variation in prices for filling Chlor-Trimeton prescriptions is as follows:

	Costs of filling Chlor-Trimeton prescriptions		
Number of drug stores		*Number of drug stores*	*Charged non-Indians*
2	$2.00	1	$1.76
1	2.75	1	1.95
2	3.00	1	2.00
3	3.25	1	2.20
2	3.75	1	2.25
1	4.50	4	2.50
1	4.75	1	2.65
1	5.00	2	2.75
1	6.50	1	3.45
		1	3.50

Costs of filling Ortho-Novum prescriptions for Indians was only obtained for eight drugstores but for non-Indians all 14 stores prices are presented:

Costs of filling Ortho-Novum prescriptions			
Number of drug stores	*Charged Indians*	*Number of drug stores*	*Charged non-Indians*
3	$2.00	1	$1.35
4	2.25	1	1.50
1	2.50	3	2.00
		1	2.10
		4	2.25
		3	2.50
		1	3.00

Only one drugstore of the 14 charged Indians consistently higher prices than non-Indians for all three prescriptions. There was no discernible pattern of pricing for the other stores. They seemed to charge randomly regardless of the prescription or whether or not the prospective purchaser was Indian or non-Indian except in the filling of Chlor-Trimeton where Indians were charged higher prices in 12 of the 14 stores.

The Tri-Faith Team reports:

> Local community organizations hope to use our report to support their argument[s] for the need for better health facilities. [In] individual cases [they] were able to use our information to improve the health of their families.

Working with United People, architectural student Barry Williams of SHP team reports:

> I built a model for urban change, a physical alternative to meet the diverse cultural and economic needs of the disabled rural and indigenous people living in Uptown. The model is a cardboard product of intangible ideas made tangible initially generated by community people and later translated and amplified into physical form by concerned professionals. The Hank Williams Village model (as it has been named) is a statement of community purpose* * * and community hope * * *. The model is, in fact, a physical explanation of community needs from the very gut of that community * * * the people * * * the idea of a cooperative village that will provide low income housing, while being at the same time an economically as well as racially integrated community.
>
> Community policy dictates the establishment of three types of housing: private ownership by resident landlords, condominium, and ownership by non-profit corporations or village cooperative.
>
> Community medical facilities will include a combined neighborhood adult and juvenile clinic.
>
> Hank Williams Village model proposes a method of rebuilding and renewal in the urban community that will lessen the dangers of changing existing community patterns.

United People, joined by private building and financial groups who support the proposal, will present its plan to the Department of Urban Renewal.

The following three students reports summarize the problems and solutions as they saw them.

It will not be helped as long as current policies, priorities, and values pervade decisions affecting the peoples' lives.—by Lynnae King (Nursing)

Uptown is a general poverty area—3b—for RMP purposes. ADC, general assistance and some help from friends are often the main means of support for many residents. Jobs are hard to find: often both older and young men must compete at day labor places. Mothers rarely work—especially among the Appalachian. Generally the blacks, whites, and Indians face many of the same basic problems as poor health, no work, no money, poor housing, sick kids, alcoholism, transiency, and the overall cultural problems of poverty. However, each group (and add to that the elderly residents) has unique cultural qualities and needs that must be considered for the effective instituting of one overall scheme for health care. Each group must be contacted and involved in

the planning of any facility or service or else the service may not be useful or utilized by them.

Health needs.—There is essentially no real health care given to the people in poverty in Uptown. Existing facilities as Infant Welfare Station Number One, private physicians, hospital clinics and emergency rooms are makeshift, patch-up operations offering nothing to contribute to the purveying of decent care to anyone and everyone.

The *elderly* are chronically ill, malnourished, diabetic, alcoholic, depressed and poor. Assistance comes from friends, small social security checks and sometimes welfare. Many are immobile, confined to room or hotel. Welfare checks are frequently stolen. Few understand the use of food stamps—besides the stores honoring food stamps usually overcharge for very low quality food. Many elderly are robbed by young boys in the area. Housing is poor; chronic diseases with complications are not treated by nearby institutions (Weiss Memorial Hospital's clinic won't handle a poor person with a chronic disease), and, of course, doctors do not make home visits. Public health nurses are likewise unavailable.

The *Appalachian whites* are often transient and therefore disqualified from public assistance. The men who head the family do not want their women receiving aid; case workers are remarkably overworked and unable to be efficient. Job opportunities are poor, even if better than in the rural South. Often the money earned cannot begin to cover city living expenses. Stores often take advantage of the "hillbilly" and young people are soon in debt with no merchandise to show for the expenditure. Housing is remarkably poor; rents are unfair; living conditions in general are subhuman. Young couples—16 years old—marry and have a child soon afterwards. The girl rarely gets prenatal care, a decent diet or proper management. More often than not, no care is received because of fear, embarassment, or husband's orders until delivery. (The infant welfare station waits for clients to come in. Given the cultural problem here this is negligent medical care!) After pregnancy the young girl continues to be anemic, weak, depressed and prone to illness.

The men coming into the city are soon demoralized by the brutality and lack of home life qualities. Many resort to alcoholism, drug abuse, violent crimes, etc., after day labor places and other unfair employment agencies, plus other living conditions 'torture' them.

The children suffer. Protein deficiency prenatally and post natally causes many cases of borderline mental retardation. Combined later with sensory deprivation, unfair and cruel experiences in school, and the problems of frustration, many of these children develop behavior disorders. Some are frankly psychotic but most are unable to do simple school tasks and fulfill expectations of teachers. They are poorly dressed, malnourished, usually suffering with upper respiratory infections, middle ear infections and ugly cuts or open wounds. Head injuries are common. Lead poisoning is a large, real danger. Much more must be done to detect and treat it immediately. Dental care is nil. Folk medicine is often used in preference to humiliation at an emergency room, doctor's office, or clinic.

The *American Indians* in Uptown have a similar plight. Discriminated against, inarticulate, shy, afraid, and demoralized, these people are getting just as poor care. They too have a large number of lead poisoned children, infected babies, mentally ill men and so forth.

The *blacks* living up on Leland, Winthrop, etc. are, of course, better off than those on the West Side. They stay to themselves and generally do not interact in the community. They too are poor, in need of health care facilities and hit by the same problems of poverty.

Organizations—

American Indian Center
Tri-Faith Employment
United People
Join Community Union
Thresholds
Welfare Recipients Demand Action
Voice of the Poor People

There is an Urban Progress Center at 901

West Montrose and Infant Welfare Station #1 near 4600 North Sheridan.

Thresholds serves mentally ill people released from mental institutions to live in halfway houses in Uptown. The Urban Progress Center and Infant Welfare Stations function as others do in the city.

The American Indian Center is excellent. It is controlled by the Indian community, has many programs and reaches many people. Do contact them for any health planning. They care and can act effectively, given the opportunity.

The United People office is currently engaged in an urban renewal struggle, but is interested in health issues. The United People leadership is an effective link between the people and businessmen in the area.

Some Uptown leaders see the problems, the causes and effects of poverty, racism, exploitive financial practices and selectively negligent health care. They should be contacted when Regional Medical Programs—at least nationally—is serious about setting up a different model for health care.

Up until now such leaders have not been incorporated into planning commissions. We have heard doctors and administrators in Uptown say: "Poor people don't know how to plan a clinic"—"we'll let them in later"—or even "we aren't servicing area 3b, so why?"

What Uptown needs is a neighborhood health center—designed to serve anyone—whether or not they can buy into current health care delivery system. No serious attempt is being made at this time to do this. Agencies recently surveyed by a local hospital were not even remotely responsible or responsive to the poverty consumers in the area. The current Regional Medical Program-stimulated planning commission, voted not to include the consumers—and only one man objected. Therefore it is clear that no responsible, honest health care planning is being done for, with, or by the poverty consumers. And none seems to be foreseeable. If some effort were to be made, the agencies and their leadership would be excellent participants.

Problems.—Our project did not attack any one problem. We should have. If SHP works in Uptown during the year and next summer the issues of lead poisoning *or* clinic admissions policies *or* pediatric care—including guidance, training residents etc. *or* prenatal care *or* hospitals—real estate—urban renewal are all worthwhile. There is no reason for SHP to enter Uptown again unless they mean business about one main problem and intend to stay until it is over. We must begin to struggle for change within our institutions, having formed alliances and allegiances with indigenous community people. All of these issues present that challenge.

We learned that what is wrong with the health care delivery system in Uptown is what is generally wrong with our society, legislation, and institutions.

The system operating there excludes, manipulates, ignores and often punishes people unable to "buy in" or present the problem at the emergency room in an acceptable, middle class way. We were appalled at the insensitivity and racism of men who are in their own and others' judgment "responsible." They are, but not to those whom their decisions affect by exclusion.

The poverty community of Uptown is in critical need—and it will not be helped in the immediate future as long as current policies, priorities and values pervade decisions affecting the peoples' lives.

Can RMP fulfill the promise of its legislation? Does it believe in consumer control—the poverty consumer, too? Is it willing to put its money onto the streets and into the controlling forces for the poverty community to be served? Does RMP wish to serve poverty areas? If so, several things must be done:

1. Abolish the current "local control" of medical school deans.

2. Strictly demand indigenous community consumer control—and that does not mean the local banker.

3. Put money into grassroots resources—hire community people to do work organizing, planning.

4. Listen to, accept, and act upon community health needs.

This would mean the end of playing politics, of allowing commissions to halfheartedly plan when indigenous people could do much of the work, and of delaying the development of decent system of health care for a poverty area. RMP could be a pioneer of sorts, despite legislative controls and an insensitive electorate. Resources must be allocated to areas and people of greatest need. Geographic and institutional boundaries will have to be disregarded in favor of responsiveness to cultural qualities, the problems and implications of poverty in America, and all the complicating aspects found in Uptown. The people in the area must have a voice in and the control of any facility entering their area.

RMP people must know that health care is a basic human right which people in a free society inherently have and must therefore, have the power to control as well as to receive it. The residents cannot do that now. And they are being excluded in current plans designed to serve 3a. Health professionals participating in current plans declaring men free to control their own lives are negligent by this systematic exclusion of those in the most need. This is immoral, and unprofessional; it must change.

Indian Summer.—by Laura J. Simon (Medicine)

The old man sighed, "I have 24 grandchildren. My wife and I had eight boys and girls. I have all kinds of grandchildren—Indians, Swedes, Italians, Spanish * * *."

"Irish, too," put in his daughter from the next room. Her husband was Irish.

He lit a cigarette, his right hand weak and trembling, and held it in his left hand to flick ashes out the tiny unscreened kitchen window. "I've been married 35 years. When I got sick a year and a half ago, I had to quit work. I was in the hospital in Wisconsin. After that, I went to stay with my sister for a while. We didn't get along, so I came down here to stay with my daughters."

The phone rang, and his daughter ran downstairs to answer her call. "Who was that" he asked.

"Marilyn," she said. "My older sister," she added for my benefit. "She lives on the South Side."

"Did she ask how I was?" asked the father anxiously.

"Yes, I told her you hadn't had any weak spells for a couple of days," replied the young mother. She was 8 months pregnant with her third child. She had not yet seen a doctor. When I urged her to do so, she said, "Oh, it doesn't matter. I can't take care of it, since I separated from my husband 3 months ago, so I'm going to adopt it out." This she told me with almost no show of emotion, as though this is just something that happens to some people, and one should not feel sorry for himself if he happens to be the victim. (I later found that this idea is inaccurate. All the Indian parents I met seemed very affectionate towards their children. I have never seen any Indian strike a child.)

Her father suffered a stroke, the illness he mentioned, and still suffers from the after-effects. His right side is partially paralyzed; his speech is a little thick. He probably drinks a lot; his eyes have the peculiar bluish glaze of alcoholics' eyes, rather than being clear and bright. Since he has no private insurance or Medicaid, he has not seen a doctor for over a year. He knows that his general assistance check is too small for his needs and realizes that he is eligible for aid to the aged, blind, and disabled; but when he went to apply, the mounting bureaucracy of question upon question, form after form, and repeated interviews with different people discouraged him from pressing on. He gave up and never went back. He recalls having applied to welfare in Wisconsin, when he had just come out of the hospital. He has never received any aid from that office. "The doctor had ordered me to drink a certain amount of wine every day, to improve my strength," he told me. "When the young man came from the welfare office, I wasn't drunk—I remember talking to him—but he could see that I'd had a few. Maybe he got

angry and destroyed my papers." I tried to assure him that this should never happen, but I am really not sure of this myself. Once this summer I was trying to help a young married woman apply for emergency assistance at the central welfare offices. I watched her go through a series of interviews, one with a fat, rude, cigar-smoking social worker. I asked the next interviewer how we could go about making a complaint against this person—only to discover that the little client was almost too timid to tell the sympathetic office supervisor that the man had talked to her loudly and roughly, the way people talk to deaf people, to people who do not understand English, or to idiots. I had to start the story. Finally she said shyly, "It was almost—"she hesitated a long time—"almost as though he didn't like Indians." That was all she would say. But if she had had enough experience with people who "don't like Indians" to think she saw something of the sort in the intake interviewer, then maybe the old man's fears were justified.

The old man spoke once more of his marriage. His wife, whom he apparently loved very much, is still alive. "She lives over there," he said, indicating a spot four or five blocks north of the window with a wave of his cigarette. "When I got sick, I couldn't work, so I told her to find a man who could take care of her. I hear she's living with a fellow who gets her everything." he said wistfully.

The old man and his daughter were the first people I interviewed in a survey which the team at the American Indian Center ran on health problems among Indians in Uptown. They made a great impression on me, as did many of the other people I met. Most suffer from the deficiency disease the whole summer project has tried to deal with: poverty, the lack of money. Some also suffer from physical illnesses, like alcoholism, tooth decay, and various other ailments which require treatment they cannot afford. We learned quite a lot about the problems these people have in finding medical and dental care when they need it, but we also learned a great deal about the people themselves.

There are some 10,000 Indians in the Chicago area, about three times as many as there were at the time of the 1960 census. They include members of about 140 different nations, from Apache to Zuni, and the largest Eskimo settlement in the country outside of Alaska. The Indian community in Uptown has been estimated at 6,000 people. This is possibly the third largest group in the area. The black population is probably a little smaller than the Indian community; the Spanish-speaking people are the second largest group in the neighborhood; and the Appalachian whites form the largest group in Uptown. The American Indian Center provides social activities, youth groups, clubs, sports teams, and social services like family service and counseling for these Indians. It is the first such agency in the country to be founded and run exclusively by the Indians themselves. It is totally independent of the Bureau of Indian Affairs, which the staff and directors feel encourages Indian people to be dependent, rather than helping them make it on their own to autonomy in the city. Only two people on the permanent staff are non-Indians, and one of these men is a student married to an Indian girl. The importance of such an organization can scarcely be overestimated. City life must come as a tremendous shock to a family that arrives in Chicago on the Bureau of Indian Affairs Relocation Program. They have been promised decent jobs and a nice place to live, a life that is better than the reservation life they are leaving. Often they find that the apartments available to families with 10 children are at best no better than the places they lived in before, while the job hardly pays enough to take care of the rent, let alone food and clothing at higher city prices. Worst of all, without the Indian center, there would really be no place where they could meet other members of their own nation socially, and indeed only one other agency, St. Augustine's Center, where they could go for help in a family crisis.

The people I met at the Indian Center were quiet and gentle, and above all, generous. Generosity is one of the chief virtues recognized in the cultures of many of the nations, along with courage, loyalty, and compassion. Strength and dignity are inherent in the manner of doing

things at the Center. I think I have learned much from the people I met: how to do three or four different dance steps in a pow-wow; how to say good morning in Chippewa; and perhaps how to look at the city through the eyes of a tribal person, to see it as an insane place where people are stranded and cut off from each other in a mad scramble for money, which is admittedly important, but not worth the isolation.

At the beginning of the summer, I had the impression that my own experience in growing up in a somewhat tribal and matriarchal Jewish family was somehow similar to the experience of some of the young Indian people. However, the matriarchy to which I belong has been an urban culture for centuries; the resemblance to a truly tribal existence is only superficial. A member of the Center staff suggested to me the distinction between the urban man and the tribal man. The urban man is essentially a product of European culture, an independent person who merely happens to belong to certain groups which have more or less influence over him, as he chooses. The tribal man, like many of the Indians, is primarily a member of a group and defines his existence and main responsibilities in terms of this group membership. As I came to realize the error I had made by equating others' experiences with my own, I realized that there are really two kinds of prejudice. One kind denies that people are similar; the other denies that they are different. No one on the project fell into the trap of assuming that people of a different race or nationality from his own have different basic needs. But we "liberals" are perhaps all too prone to lapse into the fallacy that lies at the other extreme, the error of assuming that people are *not* different. Certainly everyone needs food, clothing, shelter, someone to love them, and a place where they can feel that they belong. These are almost biologic needs, and in these respects people are similar. But not everyone sees society in the same way. It is unreasonable to expect a Sauk Indian to see American history in the same light as I do, living in northern Illinois where his nation once camped. The same government that exterminated his ancestors in the Blackhawk War gave refuge to mine. Many times in the course of the summer I was reminded of the differences between the experience of Indians in the city and my own experience.

Such a reminder came one day when I was plunking idly on an old piano in the youth room. One of the teenage boys came up to lean on the piano and watch my hands.

"You're really educated, aren't you" Joe asked.

I replied that I tried to learn things in college.

"Yes, but you're really well educated," he persisted. "I can tell by the way you wear your hair, by your earrings, even by the way you move your hands. Now take us," he gestured towards a group of teenagers who were setting up a rock band behind me. "We're just a bunch of poor, ignorant, low-down Indians. We're born losers!"

I wondered if the situation is as completely hopeless as Joe must feel sometimes. A few weeks later, while serving as my navigator on some errands for the Center, Joe gave me evidence that there is much hope for Indian people.

"Are you going to be a doctor?" Joe asked.

"Yes, eventually," I said.

"I wanted to be a doctor once, but now I don't any more."

"What made you change your mind?"

"I want to be a lawyer. I think I can help my people more that way. Look at the kids at the Center: most of them are so trapped that they'll never get anything done. I think I can do something for my people."

"What would be your strategy?" I asked.

"First, I'll get the best education I can and go to a good law school. Then I'll get my people behind me, and I'll come forward to do what needs to be done."

"Then you might end up in a legislative position?" I pursued.

"Yes, probably," Joe said.

If Joe thinks there is room for a person within the traditions of his nation to speak to the white community about the needs of Indians, he will probably succeed in doing it. I think there is also room for the converse exchange: a sincerely concerned white person can help the Indian community tackle white society and the problems it poses. Our summer at the American Indian Center was a start.

Health Care in the Indian Community.—by James Drake (Medicine) Laura Simon (Medicine), Rosalyn Netzky (Nursing), Ellyn Millman (Medicine)

In the past, several studies have reported on patterns of medical and health care in the Uptown neighborhood as a whole. Most notable of these is the Lepper-Lashof report of 1965, which proposed a system for establishing comprehensive clinics like the Mile Square project. However, although the American Indian population of Uptown has increased greatly in the past 5 to 10 years, none of the studies has yet distinguished the Indians as a separate group; and indeed no one knew just what does happen to Indians as a group. At the request of the staff of the American Indian Center, we have tried in this survey to describe patterns of medical and health care among the Indians in the Uptown area.

Indian families in the Uptown area, and a few in Lakeview, were located from a list of the names and addresses of families sending their children to the Indian Center day camp, families using the family services at the Indian Center, and families who are members of the Indian Center. House-to-house surveying was also used; each family was asked where its Indian neighbors on the block lived, and building managers were asked whether any American Indian families were renting apartments. A responsible member of each family, usually the mother or the father, was interviewed according to an interview protocol, the Health Questionnaire. The six interviewers on the project included three white medical students, one white nursing student, and two American Indian high school students.

Major findings of this survey relate to the population itself and to health care in the population. One hundred and thirty-three interviews were conducted, with single people and representatives of families, giving information about a total of 620 individuals. Of the people interviewed 113 had children, for an average of 3.4 children per family (a family is defined in this study as a unit consisting of at least one adult and the children for whom the adult is responsible). Some 67.8 percent of the families go to the American Indian Center occasionally, while 32.2 percent reported no direct contact with it. The ages of 91 individuals, mainly adults, were not determined, but the majority of the remainder were under 21 years of age, and the median age for the group fell between 6 and 10 years. Only 15 of the families had been in Chicago less than a year, while 48 had been in the city more than 10 years. The median time in Chicago was 7 years, but this does not reflect real stability of the population, since many of these families do not regard the city as their true home. They look instead to the reservation or town they came from, and many who have been here a long time still talk about returning home as soon as they can afford it. Some of these families live under extremely crowded conditions, with an average of four people in three rooms. Families of more than five people are more crowded, with an average of eight people in five rooms. Thirty percent of the families have private telephones, while 70 percent do not have them.

Data on the characteristics of the population tell only half the story. The other half, the half we set out to discover in the beginning of the study, concerns where these 620 people, half of whom are children, get medical care when they need it. Of the *individuals* represented in the survey, 34.8 percent have a family dentist while 65.2 percent of the individuals have no regular dentist. Physical illness receives more attention than dental problems: 55.8 percent of the individuals in the survey have some private physician, while 29.3 percent depend on clinics, and the remaining 14.9 percent have no regular doctors.

Of the *families* surveyed, 60 percent report having contact with a clinic in Chicago, while

40 percent have not had any contact with clinics for any family member. Of those using any clinics, 88 percent said they would go back to the clinic they had used, while 12 percent did not like their experiences with the clinic and would not go back. The clinics most used were the Maternal and Infant Welfare Station (35 interviews), Children's Memorial Hospital (20 interviews), Arvey Clinic of Weiss Memorial Hospital (six interviews), and the Argyle Clinic, a private clinic run by a physician (five interviews). Hospital experience was quite similar to clinic experience. Some 66.4 percent of the families had a member in the hospital in Chicago at some time in the past, while 33.6 percent had no experience with in-patient services in the city. Of the families that had some contact with in-patient service, 84.3 percent would return to the hospital where they received care if necessary, while 15.7 percent did not like the care they received and would not return if they could possibly avoid it. The hospitals mentioned most often were Children's Memorial (23 interviews), Cook County (17 interviews), American Hospital (15 interviews), Cuneo Memorial (eight), Illinois Masonic (six), Weiss (five), and Ravenswood (five). Most of the visits to Cook County, American, Cuneo, and Illinois Masonic Hospitals were related to the birth of children, just as most of the clinic contacts reported were with the Maternal and Infant Welfare stations. Next in importance, in both clinic and hospital experiences, was Children's Memorial Hospital. Apparently the birth and subsequent health of children receive more attention than the health of their parents.

Of the individuals in the survey, 59.2 percent, a little over half of the population, are covered by some medical insurance. Thirty-eight percent have no insurance at all; the insurance status of the remaining 2.8 percent is unknown. Of those who have any insurance, 31.8 percent of the individuals are represented by interviews which mention some unspecified form of group insurance at the father's place of work. Since some of these plans do not cover the children, the figure for the proportion of the population covered by insurance is probably too high. The Medical Assistance—No Grant (MA–NG) program, known as "the medical card" or "the green card", takes care of the expenses for a very small number and a number have medical coverage under Aid to Dependent Children or other public assistance programs for a total of about 30 percent. The Blue Cross-Blue Shield plan insures another 20.1 percent of the individuals; while the Bureau of Indian Affairs, the Army and unspecified private companies provide for the remainder.

When we asked where people go to get all the medical and dental treatment they may need, certain patterns became apparent. Nearly one-quarter of the individuals represented in the survey have both a family doctor and a private dentist. Another 8.1 percent have a private dentist and a medical clinic where they go fairly regularly. The private doctor is the sole medical contact for almost one-third of the individuals; a clinic serves as sole contact for 21.2 percent; and a dentist is the only regular medical contact for 1.7 percent of the individuals. Of the people represented in this survey 13.2 percent are medically isolated, having no regular contact at all with any medical or dental facilities.

No survey can be more accurate than the research technique used in gathering the information, and the present survey is limited in its accuracy for several reasons. Most serious of the limitations is the biased nature of the sample of people: although we found some people who were not on the Indian Center day camp or family service lists by going door-to-door, most of the families contacted were on the day camp list. Thus there may be more small children in our survey population, and fewer old people among those contacted, than are really present in the Indian community. We met no one over the age of 65, and no one on Medicare; but old people may form a higher proportion of the real community than they do of our small sample. A related difficulty is that of finding working families during the brief times when they are at home: most of the surveying was done during the day, and many people were at work. Since the survey was conducted

during the summer, it probably also missed a number of families who spend their winters in the city and their summers "back home." A further difficulty with our survey is the lack of experience of the interviewers in conducting such a project. Often our lack of experience led us to accept imprecise statements without asking for more details. As a result, our notation as to the number of people in each family who are actually covered by the father's insurance policy, the number of people in the family who actually go to the same clinic as the mother, or the number who have actually been in the hospital themselves, is not accurate. Some family histories were allowed to remain incomplete because we did not notice the gaps in our information. In general, the white students did not feel that racial fear or prejudice were affecting the interviews they conducted, so that problem probably has not affected our results.

Within the limitations of non-random sampling and errors introduced by a lack of experience, we feel that this survey points up some of the urgent health needs of the community. Almost two-thirds of the people lack dental care, both by their own report and by the observation of the interviewers who noticed that many had very bad teeth. Besides lack of education on the necessity of dental care, a major factor in the lack of such care seems to be economic: teeth just are not worth the money one has to spend to go to the dentist. We therefore suggest that a low cost dental clinic be established, on a plan similar to that used by some private hospital clinics of scaling the fees to the patient's ability to pay, to provide dental care for Indians as well as for others in the Uptown neighborhood. Vigorous education may help encourage people to use the existing facilities more; but when expense is a barrier, the only facility in the area is the McCormick Boy's Clinic for children; and a public facility of some sort could provide adequately for their parents.

Many people who had rather casual contact with large out-patient clinics, like those at Illinois Masonic and Children's Memorial hospitals, complained that they had to wait for long periods and that they never saw the same doctor twice. We realized in talking to people that some children—and adults, too—had not received adequate followup care for the problems that first brought them into the clinic, partly because there was no continuity of doctors from one visit to the next. We suggest that a family service clinic, such as the small service now being organized by Illinois Masonic Hospital, might help meet this need. The clinic need not be associated with any particular hospital, but it must have cooperation from the institutions in the area. Each family should have its own private, or, to use the fashionable jargon, "primary" physician within the clinic. He should have specialists available in a referral service, but the primary physician should be the family's main contact with the clinic and should take the major responsibility for all their medical problems. If a dental service could be associated with such a clinic, a truly flexible and comprehensive health service might be available. Such services might be financed partly by contributions from private charities or by the government, although efficient consolidation and use of expensive equipment like X-rays might cut the expenses to a point where a pay-as-you-can plan could enable the patients to support much of the clinic cost.

A person who is ill and unable to work cannot afford medical expenses; and the medical aid programs of the city welfare system, while they do help many people, still do not meet the needs of all the medically indigent. Since it was apparent to the interviewers that some people did not quite know the uses of medical insurance or of the medical card, we suggest that a public education project in these technicalities, as well as in the intricacies of getting service from existing medical and dental clinics, might help people take fuller advantage of the resources available to them now. A long-term goal that might be useful would be to establish a major medical insurance plan at low cost for people who need some insurance coverage and who do not qualify for the MANG program or other public funds.

Improvement of health care for Indian people in Uptown seems to rest ultimately on two

cornerstones which have been repeatedly mentioned: economics and education. Low-cost medical and dental care and insurance should certainly be available for people who need them; perhaps such facilities are already available in the city and could be attracted to set up agencies in Uptown. This study has not delved into the available facilities, although some fragmentary information about them is available from previous student health projects. But even the best facilities will stand idle if people are not helped and educated to use them. We think it is important for the community to establish a health committee which could do research on the available facilities, help educate the people in the use of these facilities, keep track of complaints about bad treatment, and serve as advisors to educate the clinic personnel on how they could serve the Indian community better. In the long run, the only clinics that will really succeed in Uptown or any other community will be those in which the people of the community themselves determine and control clinic policies so the clinic functions to serve them best. We believe, from our encounters with various clinics in Uptown, that it is just as important to educate the doctors to this aspect of the running of clinics as it is to educate patients to other aspects of clinics. It is a job which only people from the community can do.

Lincoln Park

Community area 7, Lincoln Park, has been subdivided into 7A and 7B. Median family incomes for all the census tracts in 7 ranged from a low of $5,344 to a high of $7,088. However, the percentage of families with incomes under $3,000 varied from one with 7.3 percent to the highest with 29.1 percent of its families earning incomes under poverty levels. (*2*) Area 7 is considered a zone 3 poverty area by CCUO criteria. However, area 7A was not considered a poverty community while 7B was considered to be a poverty area.

Area 7B was ranked in the 2nd quartile for numbers of deaths from pneumonia and influenza for infants and non-infants and also for deaths due to unknown and ill-defined causes. It ranked in the 3d quartile for deaths from cervical cancer and for newly discovered cases of tuberculosis. (*1*)

Therefore, while Lincoln Park is not one of the inner-city's deepest poverty zones, it presents many health problems to which the students in the SHO project addressed themselves.

The students conducted a health survey of residents of the community; they reviewed the area's hospital out-patient and emergency facilities; and they arrived at several conclusions and recommendations. The entire report (which also describes the ethnic composition and other parameters of the population) is presented.

"Just Getting By"—an Analysis of Health Care in Lincoln Park.—by Susan Soboroff (Medicine), George Spinka (Medicine)

Lincoln Park is a community made up of many different kinds of people. Compared with the rest of the North Side, its population has a relatively low median income. Yet it has within and near it a variety of health institutions and many practicing physicians. Is it true, then, that everyone is receiving good health care, regardless of their income? Do barriers exist that keep certain people from getting the best possible medical care? Are there problems unknown to city health departments that do not appear in incidence of disease statistics or mortality rates? Are there needs, especially among minority groups, that have not been recognized or adequately dealt with by health professionals, who are devoted to "serving the people"?

To answer these questions we asked the people of Lincoln Park who are directly involved in health care problems. A survey was taken among a sampling of the lower income residents and among hospital administrators. Their answers point to the need for better communication between these two groups.

The purpose of the questions asked of the people was to find out:

1. How the people went about meeting their health needs.

2. If they thought these means were adequate for their needs. If not, why were they not adequate and how could they best be improved.

3. How well hospitals and other health facilities in the area were being used.

4. What the people thought of the treatment they received at these institutions.

5. How the health attitudes and needs of the people related to their social and economic situations.

The method of inquiry was a questionnaire in interview form designed to document certain facts, but also leave room for as much information about health care as people wished to give. The questions tried to bring out the attitudes and opinions of those who answered, as well as facts and figures.

A total of 176 people were interviewed within an area bounded by Larrabee, Fremont, Armitage, and North Avenues—a total of about 16 city blocks. A smaller area in northern Lincoln Park was also covered between Orchard, Halsted, Diversy, and Wrightwood, and Lill between Seminary and Racine—together about six blocks. Usually, 10 families per block were interviewed.

The sampling is not random, for we spoke only to the people who were home during the day and who were willing to answer our questions. On many blocks this biased our responses toward the large Spanish families in which the mother was most likely to be home and most receptive to us.

The southwestern part of Lincoln Park was chosen as a sampling area deliberately, because the population is the most varied socially and economically. Thus it was thought the main health problems would be concentrated here. That these problems occur in other parts of Lincoln Park is shown by the interviews from the northern areas.

Many of the statements made below, other than the statistics, are subjective impressions. They come out of personal contact with the people and with their surroundings. We feel that this can only add to the figures, however, just as the individual examples illustrate the reality much better than the statistics can. We did not wish to document the state of health of the people, though many diseases were found. Rather, we want to consider the social, psychological, and economic problems that are involved in getting medical care.

The questions asked of five hospital administrators were not systematized. Specific questions about their available facilities were designed to bring out their awareness of the community's needs and their willingness to meet them. Planning for the future was an important area of concern. We have tried to evaluate from these answers, the hospitals' attitude toward the Lincoln Park community and what their role will be in future planning for the community.

The total number of people interviewed was 176. They frequently will be broken down by ethnic groups: white 88; Spanish 70; blacks 18.

The types of health care received by all roughly fell into three general categories. The first was the most secure, in which the people had hospital insurance and a family doctor, a private physician whom they see regularly. The second group of people were "just getting along" in their health needs. The type of care they received was usually fragmented, crisis-oriented, and often too costly for their incomes. They sometimes held hospital insurance, but could not afford large hospital bills. They often cited a private physician, but saw him only when they were ill. Many in this group used clinics and might be on welfare. Those in the third group either have no knowledge about health facilities available or no concern about them. They had no private physician or health insurance, or hadn't seen a doctor in many years. The breakdown of those interviewed into the three groups are:

	Percent			
	Total	*Whites*	*Spanish*	*Blacks*
Have family doctor and insurance	31	45	16	12
Just getting along	60	48	72	76
No knowledge or concern	9	7	12	12
Total	100	100	100	100

The majority of the people interviewed fall into the second group.

A significant number fall into the third group.

The whites are fairly evenly distributed between the first and second groups, but the Spanish and blacks fall mainly into the second.

To some extent, length of time in the community determines the kind of health care received. Familiarity with services available and positive experience with them often lead to better care. The dynamics of the population are:

	Percent			
	Total	*Whites*	*Spanish*	*Blacks*
In area 1 year or less	20	12	25	41
In area 1 to 5 years	36	24	49	41
In area over 5 years	44	64	26	18
Total	100	100	100	100

The majority of white are well established in the community.

Many of the Spanish are relatively new and nearly a quarter are very new.

The blacks are the newest to the area, few having lived there over 5 years.

Health insurance is an indication of income level and of attitude about health needs.

	Percent			
	Total	*Whites*	*Spanish*	*Blacks*
Have insurance	60	73	51	50
Self-paid	25	12	40	25
Welfare and Medicare	15	15	9	25
Total	100	100	100	100

A slight majority of the people have insurance; with welfare and Medicare, 75 percent are covered by third party payment of some kind.

This leaves 25 percent of the people who must pay for all health expenses themselves.

The distribution of insurance among the ethnic groups differs significantly.

Having a private physician and seeing him regularly is the ideal form of health care in our society. This is our definition of a family doctor. He must have an interest in the health as well as the disease of the whole family.

	Percent			
	Total	*Whites*	*Spanish*	*Blacks*
Have a family doctor	50	70	36	18
Use a private doctor	26	12	36	41
Use no private doctor	24	18	28	41
Total	100	100	100	100

One half of the people have a family doctor. One quarter see some private physician, and nearly one quarter see no private doctor at all.

A large majority of the whites have a family doctor, though a significant number have none.

The majority of Spanish and blacks do not have family doctors. The blacks have the highest percentage without a private doctor of any kind.

Dental care is the least health concern. Most people who see a dentist go only when they have trouble; many others do not go, even when they have trouble with their teeth, for a variety of reasons—money, time, discomfort among them.

		Percent		
	Total	*Group I*	*GroupII*	*Group III*
See a dentist	94 (53)	44	15	18
Do not see a dentist	68 (39)	46	82	82
Use a dental clinic	14 (8)	10	3	--
Total	176(100)	100	100	100

NOTE—Numbers in parentheses are percentages of total.

Most of those who have seen a dentist fall into group I.

Those who are "just getting along" in group II usually do not see a dentist.

Use of private doctors and clinics show some of the patterns for attaining medical care. The heavy use of clinics is evident.

	Total
Use private doctor only	71 (44)
Use private doctor and clinic	64 (40)
Use clinic only	20 (12)
Use no doctor or clinic	4 (4)
Total	159(100)

NOTE.—Numbers in parentheses are percentages of total.

Nearly half of the people see a private doctor only; the majority of these are family doctors.

Almost as many use both clinic and private doctors.

More than half of the people use a clinic.

Answers relative to emergency care show knowledge of and confidence in the area hospitals.

	Percent
Had experience at hospital named	60
Had no experience at hospital named	19
Named clinic or private doctor	8
Didn't know where to go	13
Total	100

A substantial percentage of the respondents have had previous experience at a hospital and would rely on its emergency room.

13 percent did not know where they would go in an emergency.

Use of the area's hospital out-patient and emergency facilities. The totals for emergency room are the number of times it was mentioned, not necessarily used.

Hospital	*Clinic*	*Emergency room*
Children's Memorial	40	25
Grant	13	26
Illinois Masonic	12	18
Northwestern	8	5
County	5	10
St. Joseph	3	7
Augustana	3	15
Alexian Brothers		5
Henrotin, Roosevelt Memorial		2
American, Columbus		3
Total		116

Clinics used most frequently are Children's Memorial, Grant and Illinois Masonic.

Heavy use of Children's indicates an emphasis on child, rather than adult care.

Hospitals such as St. Joseph and Augustana are mentioned more frequently for emergencies than clinic usage.

Group I: Those people classified in group I in general have their medical needs well taken care of. They meet four basic criteria. First, they receive preventive medical care, usually from a family doctor to whom they go for regular checkups. Second, they are able to finance extended sick care treatment either through private health insurance, Medicare, a welfare medical grant, or prepaid union clinics. Third, they are knowledgeable about the existing health care facilities in the community. Finally, they see the need and importance of good medical care and are conscientious in attempting to obtain such care.

A profile of a typical group I subject would include the following characteristics: White; well-established in the neighborhood—often having lived there more than 5 years—steadily employed as a white or blue collar worker, businessman, or professional; has a family doctor, very often located outside of the Lincoln Park area; tends not to use out-patient clinics; if he does use a clinic it is most likely to be Children's Memorial, Augustana, or Northwestern University; has a dentist; has health insurance; knows of a local hospital to go to in an emergency, most likely Grant or Augustana.

Group I families are more likely to be smaller, with fewer pre-teen children than group II or group III families. There are also many senior citizens within the group, who are likely to be taking advantage of or relying on Medicare when they are ill. In conclusion, the most significant fact about the group I subjects is that they are only 32 percent of the total sample.

Group II: Many different types of people are in the category of those who are "just getting along" in health care. They have neither a family doctor nor health insurance, our criteria for being medically secure. Most of them have had some experience and have some knowledge of health facilities in the area, but would like to know more. Two definite patterns do appear within this group, one for the Spanish and another for the black population. A general description of each as well as specific examples from the survey follows:

The Spanish-speaking Americans are relatively new to the area; most have lived there less than 5 years. Some adults speak no, or very little English. Families tend to be large, with many young children. Almost all of the men work, usually as factory workers or they own small businesses. Very few are on welfare.

About half of the people can afford health insurance; the others must pay all their medical expenses themselves. They prefer to see a private doctor who speaks Spanish and who is geographically close when they are ill; few of these physicians are their regular family doctors.

The Spanish utilize clinics whether or not they have a private doctor. Those with chronic conditions are especially likely to use a clinic, and families with young children very often go to Children's Memorial. The infant welfare station on Halsted and the clinics at Illinois Masonic and Grant hospitals were also well used. They would turn to these in emergencies.

Most of the Spanish people do not have a dentist, but some wanted to find inexpensive ones. Children had received immunizations either at the clinics or in school. On the whole, their attitude toward health care is conscientious, but few can afford the cost of a regular family doctor or even insurance. Language barriers also keep them from dealing with large, unfamiliar institutions and from obtaining more information about available facilities. Women with many small children and working husbands have difficulty getting to doctors and clinics, even when they are very ill. They would benefit by having a neighborhood clinic that offered a comprehensive and personal, family-oriented approach to health care.

Some examples of the Spanish interviewed:

1. Mr. S. has seven children and has lived in the area 2 years. His take home pay comes to about $80 a week. They have no family doctor, but he brings the children to two frequently named Spanish-speaking physicians when they are ill. One child with a heart condition is about to be operated on at Children's Memorial. Mr. S. must take the child to the clinic each week. His insurance will cover the boy's hospitalization, but it does not pay for private office visits. His wife delivered at County Hospital. The family has no dentist. In an emergency, they would call their doctor. Mr. S. would like to see more convenient clinic facilities in the area.

2. Mrs. S. has five children and has lived in the community 9 years. She normally goes to one of the Spanish-speaking doctors first when she is ill. A school nurse suggested that she take her children to St. Joseph's eye clinic for glasses. When she registered three children there they received complete physical exams. She has gone to the infant welfare station and to hospital clinics for prenatal care. Her dentist is in the area, and her husband has Blue Cross insurance from work. In an emergency, they would go to St. Joseph.

3. Mrs. C. has nine children and has lived in the area for 3 years. Her husband works as a laborer and must pay for all medical expenses himself. He goes to one of the Spanish-speaking physicians only when he is ill, but the children are seen regularly at the Children's Memorial clinic. These visits cost only $1, but there is a long wait. Mrs. C. received prenatal care at the infant welfare station and was delivered at County. They used to see a dentist at Casa Central, but can not afford it now. In an emergency they would go to Children's Memorial or to county and not to Augustana, where the expense, they said, is too much.

4. Mrs. H. has seven children. She does not speak English and has lived in the area for 5 years. She brings her father to a Spanish-speaking doctor when he is ill. These visits cost between $5 and $8. Her children were born at County and Illinois Masonic hospitals. They do not use a clinic, and she would like to know more about clinic facilities in the area. They have no dentist, and she does not know where she would go in an emergency. One child had stitches taken at Grant where, since they have no insurance, the cost was too high.

Although conscientious, the health picture of the average Spanish family is a confused one. One or two private doctors, sometimes a number of clinics, different hospitals for deliveries, emergencies, and chronic conditions, and no place for regular care. Neither private physicians or hospitals are concerned about the welfare—healthy and diseased—of the whole family. Even small emergency costs are often a burden, and extensive hospitalization is impossible for them to afford. Government programs such as Medicaid do not pay for these ambula-

tory services, and their low, but regular income usually makes them ineligible for poverty grants. In addition, these programs and clinic facilities were often unknown to the Spanish.

The blacks in group II live, for the most part, south of Willow. They are newer to the area than the Spanish; very few have lived there more than 4 years. Families tend to be small and occupations range from laborers to mailman to laid-off. A number are on welfare.

The average person does not have a family doctor or even see a private physician. More often they turn to a clinic when they are ill, and the clinic is very likely to be Cook County Hospital clinics or Children's Memorial. For prenatal and infant welfare the Board of Health clinics are used.

Most of the families are covered by some form of insurance-hospitalization or welfare medical grant. They rely most often on County Hospital in an emergency. The only other hospitals used are Henrotin and Roosevelt, both known for the integrationist policies, and a few private clinics on the near north side. They usually do not see a dentist because of the cost.

From the brevity of their health care descriptions, the blacks do not seem to have much experience with the different health facilities in the community. Cook County Hospital is always available, and, though many are dissatisfied with it, they continue to use it. The private doctors they see are mostly welfare physicians located near the Cabrini Housing Project who see far too many people a day to be practicing good medicine. On the whole, then, their attitude seems to be a resigned one, giving health care a lower priority and getting help wherever they can when sickness or injury develops. Some typical examples of the blacks interviewed are;

1. Mrs. B. has lived on Burling 1 year with her one small child. She has no family doctor, but she does take her child to Children's Memorial clinic once a month. Her child has been seen at the infant welfare station also. For prenatal care she went to the Cook County Hospital clinic and was delivered there. They have no dentist. Mrs. B. is on welfare and has a medical card but would still travel to County Hospital in an emergency. Her experience there in the past was not good.

2. Mrs. L. is a young mother of three and has lived in the area 2 years. At p[illegible]ent her husband is looking for a job. They have no family doctor, but do have hospital insurance. She had experience at St. Joseph clinic when the board of Health clinic sent her there as a high risk pregnancy. For the delivery she went to Passavant and was treated well. She doesn't know of a dentist in the area or of a clinic where her older children can get shots. She has used Children's Memorial clinic in an emergency, but would rely on Cook County in the future.

3. Mr. L. has lived in the area for 2 years with his wife and two small children. His wife now supports the family. When ill, he goes to a physician on Chicago Avenue or a to a medical center on Division. His children were born at County Hospital and his wife received no prenatal care. He does have health insurance. He would go to Henrotin in an emergency where he has been treated for injuries in the past.

4. Mrs. S. is the mother of two children. Her sister has supported her for the 2 years they have lived in the area. They have no health insurance and no family doctor. She has gone to a doctor on Clybourn and to clinics at County and Children's Memorial hospitals. Her children were born at County and they would probably go there in an emergency.

Some of the whites in group II might best be described by a few examples. For them, the main problem in getting good health care seems to be expense.

1. A family in northern Lincoln Park with two children has been in the area for 3 years. The husband does construction work. The infant gets regular care at the Diversy Clinic and the older one is seen at Illinois Masonic clinic. For the last delivery at Illinois Masonic, which was a cesarean section, their insurance covered $200 of the $1,100 hospital bill. They would go to Illinois Masonic in an emergency.

2. Mrs. S. has a family of six in northern

Lincoln Park. They had a family doctor until recently, but can't afford one now. She takes her children to Children's Memorial clinic. Her last three were born at home, and they do not have a dentist, both because of the expense. The family is covered by Blue Cross, but it does not pay for all of their medical costs. She would like to have more low cost and convenient clinic facilities and to know more about the health facilities now available in the area.

Group III: Subjects in group III are the least well taken care of. They receive little or no regular medical care. They are often new arrivals in the community. They are usually Spanish and speak little English, or black. They have no family doctor, although they may know of a doctor whom they can go to when they are sick. They generally have no health insurance and do not know of a place to go in an emergency. Most do not know of, or use, any outpatient clinics. Finally, they receive no dental care.

Some specific examples may shed some light on the special problems of the group III people:

1. Mrs. A. is Spanish. She has two children ages 6 and 7 and has been in the area only 3 months. She has no regular family doctor, but takes her children to a doctor on Clark and Division in time of illness. She doesn't know of any clinics in the area, nor does she know where she would go in an emergency. She is on welfare and has a medical card. Her problem is basically lack of knowledge of the existing medical facilities in the area, for she is new in the area and has difficulty with the language.

2. Mrs. B. also is Spanish and has five children between the ages of 9 and 16. Her husband is a painter, and they have lived in the area for 2 years. They have no family doctor, and do not use any clinics; they do visit a doctor on North Avenue for minor illness or injuries. They have no insurance. Their problem is primarily financial. The husband is working and earning too much to qualify for welfare grants. Yet his income is still too low to cover the expense of a family doctor or health insurance.

3. Mr. C. is white and has lived in the area for 18 months. He is unmarried and works as a teacher. He does not see any doctors, nor does he know of any in the area. He doesn't use, or know of, any clinic although he does have health insurance. His problem is not a financial one, nor is it really a lack of knowledge. It is simply an indifferent attitude towards medical care—a belief that it is unnecessary and undesirable to guard his health through regular visits to a private doctor or clinic.

4. Mrs. D. is white and has been living in the area for 1 year. She has three children ages 2, 3, and 5. She and her family do not see any private doctors for the reason that they cannot afford to. They do not have insurance for the same reason. The only medical facility which her family uses is the infant welfare station on Clark Street. This family is obviously in need of information about the available clinic facilities that are designed to serve low income families.

In conclusion, the people in group III receive inadequate medical care for one or a combination of the following reasons: They cannot afford adequate care; they do not know what facilities are available to them within their income range; they fail to see regular care as important or necessary; they are reluctant or afraid to use institutions that are unfamiliar to them.

There are seven hospitals in or very close to Lincoln Park. They range in size from Roosevelt Memorial with 125 beds to Illinois Masonic Medical Center with 544. They range greatly in origins and in the kinds of services provided, thus in character. Columbus, for example, has no out-patient clinic, but Grant has been providing clinic services for many years. Does a private hospital have an obligation to change its character to fit the changing needs of the community around it? We believe that it does, and we have evaluated the answers of hospital administrators within this context.

For the most part, the hospital is run by a board of directors who are representative of wealthy business interests on the North Side. An exception is St. Joseph whose board is

made up of nuns but, they are advised by a board of community businessmen. Nowhere on these boards or advisory groups are the lower income people or their interests represented. An exception is the model clinic run by Children's Memorial at the Cabrini Homes. Up until now, however, the advisory board of Cabrini residents has had only a minor role in the clinic functions and do not have the legal responsibilities or interest of a true board. As a result, the clinic is having serious problems in relating to the community.

The private hospital can avoid looking out the window under the pretext that its medical staff determines the makeup of its clientele or inpatients. The results of this and other studies, however, point to the pressing need for more and comprehensive ambulatory or out-patient services. Five of the seven hospitals offer out-patient services in varying degrees. The three largest are open every day all day, although one still works on the old no-appointment system. The two others operate for a limited time with volunteer staffs. This is an outmoded, charity-clinic way of offering service. It has no place in a health delivery system that must move toward more ambulatory, comprehensive care provided to all that need it at the hospital level.

The emergency room is open 24 hours a day in each of the Lincoln Park hospitals and to anyone who needs it. A few of these are seriously overcrowded, especially after clinic hours; these are the same hospitals that are well known and trusted for their out-patient facilities, staff of community physicians, and acceptance of minority groups. Much of the overcrowding could be relieved by other hospitals in the area, and by extending clinic hours into the evening and weekends. The need for nonemergent ambulatory care after clinic hours was shown by the fact that out of 8,200 patients seen at the St. Joseph emergency room, only 26.6 percent of these were trauma or urgent cases. Similar stories were told at each of the other hospitals.

One method for lowering hospital costs is to coordinate services with other institutions so that expensive facilities are used in the most efficient way. The Lakeview-Lincoln Park Hospital Planning Council is meeting now and trying to avoid duplication of services among the area hospitals. The council also has the potential to plan an efficient health delivery system that would reach everyone in the Lincoln Park area, but has few plans like this. They should be discussing how the hospital can participate in community affairs and how the community can participate in hospital affairs through free interchange of ideas between the council and the people. An awareness of their needs and a willingness to listen to their suggestions and deal with them should be an integral part of the council's activities.

Illinois Masonic.—The administration of the large, recently named, medical center is alone in its commitment and involvement with the community around it. It is in direct communication with Lakeview organizations and agencies, and the hospital takes a leading role in community affairs by serving the needs.

Some examples of the wide array of services it provides are: an extensive outpatient clinic that emphasizes personal care, and which offers both sick and well care; a free Pap smear program; physical exams for public schoolchildren; psychiatry courses for local clergy; Spanish and English courses for hospital personnel.

In the near future Illinois Masonic plans to build a large addition devoted mainly to ambulatory services. It will include a family practice program in which interns will be responsible for the health of five clinic families from the community. In this way general practitioners on the staff can teach the lost art of family doctoring while whole families receive thorough and personal care. If all of the hospitals in the area participated in a program like this, a much more significant part of the lower income population could be reached.

St. Joseph.—The hospital was founded and is administered by a Catholic order, the Daughters of Charity whose goal was originally to "serve the poor." The attractive new facilities do include a clinic with a wide range of specialty services, but its hours are limited

and its existence is little known. The Board of Health also runs a referral clinic there for high risk pregnancies and very ill infants. Its location, however, has kept it out of reach of the people who need it. Better public relations and reach-out programs would help to make it more widely known and used.

The administrator is head of a long-range planning committee to define the hospital's role in health care of the city. Nowhere do community organizations, churches, schools, or individuals appear on this committee to participate in the planning. However, the council is seeking the people's involvement in a referral service that was suggested for the Cabrini Homes. They want to improve medical care by sending patients to existing facilities and thus making the best use of these resources. Sister Vincent hopes to find interested members of the community to participate in this project.

Children's Memorial.—Children's is a pediatric hospital that serves the entire North Side. Its major service to the community is a large outpatient clinic that is widely used. Long waits and only daytime hours are complaints that the administration is aware of and trying to improve, though slowly.

The hospital also operates a neighborhood clinic on the near North Side that offers both sick and well care without charge, unlike the hospital clinic. The clinic claims a community advisory council, but the residents have little real say in how the clinic is run.

In this sense, the administration of Children's seems only slightly open to ideas of community participation in or even community communication with the hospital. It is aware of some of the problems, but has taken few steps to improve the situation.

Grant.—Grant has a history of providing outpatient services to the community. It is planning to expand these facilities in a new building and even now is equipped to take more patients. A problem for the hospital is how to make the people more aware of the facilities that are available. We suggest that they involve themselves, as Illinois Masonic has, with community organizations, churches, schools, etc., and take a leading role in community affairs. Better communication and understanding will lead to better utilization of the clinics and, of course, to better health.

The medical staff at Grant is representative of many ethnic groups, and includes a number of physicians who practice in the Lincoln Park area. The hospital also trains many paramedical personnel, technicians, and nurses. It is very active in future planning on the Lincoln Park-Lakeview Planning Council.

Augustana.—Since it is owned by the Lutheran Church, Augustana serves patients from a wide area. Only one-half of the hospital's inpatients come from Lincoln Park or contiguous zones. Today it offers little to the lower income people of the Lincoln Park area. Its new clinic operates on a referral basis for obstetrics and medical problems. The clinic is not being used to capacity, and the emergency room is not crowded.

Augustana plans a large expansion program and has already acquired much land from Urban Renewal agencies. The hospital has purchased and torn down "slum housing" to put up more inpatient facilities. According to a Hospital Planning Council report, no more beds are needed on the North Side. According to us, more ambulatory, low-cost services are needed. Clearly, Augustana is not moving to meet the needs.

On the basis of interviews with people of the community and with local hospitals, the following conclusions and recommendations are offered.

1. The ideal of good medical care is in a large measure defined by the concept of preventive medicine. Preventive medical care involves safeguarding the health of the individual and the family through regular visits to a qualified physician who is familiar with the medical history and special medical problems of the family members. The results of the survey show that comprehensive care of this kind is not a reality for many of the people interviewed. *Only one-half of these people have a family doctor.*[1] Roughly one-fourth have con-

[1] All emphasis, the students.

tact with a private doctor, but only go to him when they are ill or injured. Finally, *one-fourth of those interviewed have no contact with a private physician and must receive all their medical care at clinics, emergency rooms, or not at all.*

2. Economics obviously play an important role in the kind and quality of health care received. Those most seriously affected by their ability to pay are not the indigent or unemployed whose medical needs are paid for by the government, but rather they are the people in the lower middle income range. These people earn too much to qualify for any kind of government assistance, and in some cases to be eligible to use outpatient clinics. Yet they cannot afford the cost of a private physician, dental care, or extended hospitalization. Even when these individuals have health insurance, the policy usually does not pay for preventive, ambulatory, or dental care, and it does not pay the entire cost of hospitalization. *Moreover, a quarter of the people do not have health insurance of any kind.* To sum up, most of the people in group 2 are "just getting along" because of their inability to pay for good medical care, and *their situation applies to more than half of the people interviewed.*

3. There are differences in the quality of medical care received according to racial and ethnic groups. For instance, 43 percent of the whites interviewed fall into group 1, while 16 percent of the Spanish and only 12 percent of the blacks are in this group. *The large majority of Spanish and blacks fall into group 2.* The reasons for these differences are in part financial; the minority groups generally find themselves in the lower income brackets. Another reason is that white people are more knowledgeable about the facilities which are available in the community for they have lived there longer on the average. A third reason involves attitude and cultural factors. Many of the Spanish people are isolated from the white society by their language and unfamiliarity with American life. They are frightened and embarrassed by large institutions, and may be reluctant to seek help unless they are very ill. For the black people who rely heavily on County hospital, some reason—be it discriminatory policies, unfamiliarity, or simply force of habit—has kept them from taking full advantage of the health facilities available in Lincoln Park.

4. The kind of dental care received is another index of the quality of general health care. Among the people interviewed, regular dental care was rarely reported and occasional care was received by only half. *Roughly 40 percent received little or no dental care.*

5. It must be emphasized that 10 percent of the people interviewed made up group 3, and received little or no medical care at any time.

6. On the basis of hospital interviews, it is obvious that a general lack of communication exists between the hospitals and the community. True grassroots community representation on hospital policymaking and planning boards is nonexistent. *As a result, hospitals have ignored the immediate area or are attempting to define its needs without consulting its needy people.* A number of the hospitals are moving ahead with expansion and building plans which at this time are not the most effective solutions to the community's health problems.

On the basis of the preceding conclusions, a number of recommendations for future courses of action aimed at improving medical care can be made.

1. Hospitals should expand their existing clinic facilities; all future building and expansion planning should include provision for more ambulatory, low-cost services. The lead in this area has already been taken by Illinois Masonic Hospital, which is planning a $5 million addition devoted mainly to ambulatory clinic care.

2. Hospitals should take steps to enable more people to use clinic facilities. This would involve extending clinic hours into the evenings and weekends, so that people who work or have small children can make use of them.

3. Hospitals must reach out to the community and assume an active responsibility in persuading the public to take advantage of their facilities. As a first step they can make their services known through community newspa-

pers and by distributing information directly to community organizations and agencies. They should also work to remove the psychological barriers which keep people away by hiring more Spanish speaking, Oriental and black medical personnel. The impersonality of the clinic could also be improved by assigning each patient to his own doctor.

4. Hospitals must undertake more imaginative programs aimed at low-cost preventive medical care for the community. Illinois Masonic is again leading by developing a family practice program. All teaching hospitals in the area could and should experiment with similar programs.

5. Hospitals in the area must build and expand true channels of communication with the community if they are to serve its needs. This does not mean talking only with associations of local businessmen or professional people. It means dealing with organizations that have direct contact with the average person. In Lincoln Park these would include the Northside Action Group, Neighborhood Commons Corp., Concerned Citizens of Lincoln Park, C.B.C.A., block clubs, churches such as St. Teresa's and Mt. Olivet, welfare unions, P.T.A.'s, settlement houses such as Christopher House, Wrightwood Center, J.Y.D.C.'s, boy's club, etc. It is only through such dialogue that the health needs of the community can be accurately assessed and appropriate solutions developed. Only through dialogue and direct participation of the people in planning and implementation can projects aimed at improving health care have any hope of success.

The above are steps that can be taken now for improving medical care. In response to the questionnaires specific suggestions and comments were made that bring out the needs of the community. Some of those mentioned are:

1. A general neighborhood clinic for the whole family.

2. Homes for retarded and delinquent children.

3. School nurses and visiting doctors.

4. A referral service for medical problems.

5. Better housing.

6. Doctors should be more personal and give the patient more information about his illness.

7. Hospitals bills are too expensive.

A school-community representative who is deeply involved in the medical problems of the children at Arnold and their families and is a mother herself gave these suggestions:

1. Where to go when the children are handicapped and are turned away from school.

2. How important it is for family to have TB X-ray once a year.

3. Where to go when your child is retarded.

4. How important it is to have a diabetic test.

5. How important it is for younger girls and women to get prenatal care as early as possible.

6. Whom to get information for psychiatric help.

7. Our neighborhood needs to know where to go for Alcoholics Anonymous help.

8. How important children's eyeglasses are for them in and out of school. Where to go and find out if parents also need glasses.

9. Need for more dental care.

10. Medical care for fathers who are along with children or grandparents also (i.e., clinic hours open after regular working hours).

11. Health Fair should be in the community centers at least 2 days before moving to another center until all centers in the community are covered for 1 or 2 weeks at least.

12. Cab service for people who are alone and can't travel by themselves.

This community representative's suggestions emphasize the need for more information about available resources and educating people to take advantage of them. Psychiatric help has not been dealt with in this report, but the need for more and better facilities has come up frequently. The Health Fair sponsored by the J.Y.D.C. last spring was successful in helping to educate the people as well as screening them for a number of diseases and disabilities. However, its effect on the community was limited by its single location and short duration. Longer and more widely distributed fairs of

this sort would have a greater influence on the health of all of Lincoln Park.

Other communities and groups have worked toward better health care through more extensive and long-range projects, such as prepaid group practices and neighborhood health centers. Some information concerning these follows as well as our evaluation of their applicability to Lincoln Park.

In any discussion of long-range solutions to improve the health of an entire community, prepaid group practice plans or health insurance offering direct medical services should be explored. Essential to such a plan are: (*a*) The people who subscribe pay a set monthly fee into a common fund, in return they receive medical service from a group of doctors who are paid from the common fund; (*b*) these services include preventive care, ambulatory sick care, and intensive sick care with hospitalization; (*c*) the physicians who render care are paid a fixed salary, instead of fee-for-service; and (*d*) they may render service in their own private offices, but more likely use a special clinic facility set up for the subscribers of the plan.

Advantages to the subscriber are that through a reasonable monthly rate, like an insurance rate, the patient is relieved of the costs of most preventive and ambulatory medical care as well as possible extensive hospitalization expenses. The salaried physician is freer to give the patient more thorough and personal attention. Advantages to the doctor are that he is relieved of the paper and clerical work involved in billing patients, and he is spared the expense of maintaining an office.

Group practice plans similar to the one above are operating successfully in a number of places in this country and Canada. The Kaiser insurance plan in California and the health insurance plan in New York have resulted in better health planning for the insured through more efficient and effective medical service. Studies show that for families enrolled in the Kaiser plan, the total cost of health care is only 70 to 80 percent as much as employees under another plan.

In each case, however, these programs have been begun by a corporation or government with a great deal of organizing power. A core of compulsory subscribers has been necessary to provide enough initial capital for setting up the clinics and operating them. The plan should be a serious possibility in health care planning for Licnoln Park.

Consumer Participation.—For a successful Neighborhood Health Center, a strong community organization interested in health care and a willing hospital staff are needed.

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The Latin American Defense Organization (LADO)

This organization came into being approximately 2 years ago after rioting in the Puerto Rican community had sharply focused attention on some of the problems besetting the Spanish speaking people in Chicago. It has been a service organization in the sense that it tries to aid people and families with problems but it is basically attempting to organize the Spanish-speaking community around the issues of welfare, health, housing, and jobs. It is not specifically a community organization since Latin Americans live in a number of different communities located in poverty zones of the city. As a result of urban renewal programs on Chicago's near west side, large numbers of Puerto Ricans and Mexican Americans were displaced and moved to different communities, just north and south of the near West Side.

Three health science students and two high school interns were assigned to work with LADO in setting up two projects. One was the organization and staffing of a day care center and nursery for children of Spanish-speaking families and the second was a program to screen children for intestinal parasites, a health problem in the Spanish community.

Between 15 and 20 families responded to the day care and nursery center. Approximately

100 stool specimens were collected and sent to the Board of Health for analysis. It was hoped that this latter program might be a step toward the construction and maintenance of a parasite detection and treatment center.

One of the health science students, reported on her summer's experiences, in part, as follows:

An educational system which strips them of their cultural heritage.—by
Mrs. Terry McMurry (Sociology)

From our combined experience among Spanish-speaking youth in the Southwest, in New York City, and in Chicago, we recognized the crying need for *such* materials, and set out to fill this "informational vacuum" as best we could with our limitations of time and money.

The first few weeks of the summer were spent on a "snipe hunt" for available materials on the history and culture of Spanish-speaking groups in this country. We contacted such institutions as the Chicago Board of Education and the University of Chicago Lab School and found no materials whatsoever. Afterward we outlined the relevant topics which might be discussed under the heading of "Problems, Issues, and Answers of the Spanish-Speaking Population." They included:

1. General history of the three major groups of Spanish-speaking people in the United States—Spanish Americans, Mexican American, Puerto Ricans.

2. Discussion of the problems of Spanish-speaking people in both urban and rural settings, and their relation to problems of other minorities.

3. Treatment of the contemporary movements among Spanish-speaking people to demand equality and justice as citizens of the United States—Reies Tijerina's Land Grant Movement, Cesar Chavez's Farmworkers' Union, Corky Gonzales's struggle against the urban establishment, et. al.

It was decided at this point that film strips and tapes would be the most appropriate means to illustrate these topics.

The tasks of writing, taping, shooting pictures, etc. were divided among the three of us. Much of my SHP salary was set aside for purchases of equipment and materials. At the present time, the writing and taping tasks assigned to my husband and I have been completed, in addition to a brief bibliography of available references. Miss Tatman will complete the film strips when her position with LADO becomes less demanding. She anticipates cooperation from neighborhood groups and perhaps from public school officials in trying out our materials in the fall.

It may be asked how "medically relevant" our summer's work has been. Admittedly, our work will not reduce the chronic physical ailments of the Spanish-speaking poor in Chicago, nor ameliorate the discriminatory treatment they receive from the medical "establishment." We hope, however, that it will ultimately foster emotional and psychological well-being among students who are presently being harmed by an educational system which strips them of their cultural heritage, and denies them the right to self-respect and pride in their specialness. The importance of teaching "Black History" to our school children has finally been recognized by the educational hierarchy. Likewise, we feel, the importance of educating our youth to appreciate *all* minorities must be seen in the near future.

Erie House

This is a settlement house on the near Northwest Side. In addition to sponsoring a number of social and welfare programs, it houses an outpatient clinic staffed mainly by Northwestern University medical students.

The community it serves is bounded on the east by Halsted Street (800 west); on the west by Ashland Avenue (1600 west); its northern boundary is Chicago Avenue (800 north) and its southern boundary is Grand Avenue (530 north).

The population residing in this section of community area 24 is mixed. It is composed of Spanish-speaking peoples including Mexican Americans, Puerto Ricans and Spanish Americans; white in-migrants from Appalachia and

white Polish and Italian residents, usually older people; and a small Negro population. There are probably about 10,000 people in the area. Median family incomes in these census tracts was between $4,000 and $5,000 per year in 1960.

The students reported that the health resources most frequently used by residents of this part of the community include St. Mary of Nazareth (the nearest geographically), Children's Memorial and Cook County Hospitals, the Northwestern Medical Clinics and Hospitals and Presbyterian-St. Luke's Hospital.

The utilization of health resources seemed to be affected by a number of factors unrelated to health itself. Quoting from one of the reports:

> Many claim to have private doctors, often because they seek doctors with whom there is no language barrier (Spanish); [and] also as a matter of pride rather than accepting public aid.
>
> A large percentage of the people hesitate to use doctors and hospitals because of language barriers, money, negative experiences, long waiting periods, rushed [and] impersonal contacts.

And from the same report the health knowledgeability in the community was described as being at the individual level only, as follows:

> These people do not see health problems as community problems requiring community action [but] rather as their own individual family problems, e.g., mental retardation. They have not seen good health care and have no concept of what we term quality care. Therefore, they are grateful for what we consider to be fragmented health care. In addition, there is a great reliance on, and faith in, folk medicine. These people actually constitute a rural society that is merely existing in an urban setting.
>
> Health concerns pertaining to children have much higher priority than those pertaining to the adults/parents * * * [they are] less concerned with subtle or nonobservable problems which do not interfere with their immediate, every day activities. Thus, they seek [a] doctor when symptoms interfere with their work or other activities * * * Still health receives less attention than (1) food; (2) housing; (3) employment; (4) recreation; (5) education; and (6) health.

The students worked primarily in the Erie Settlement House Clinic. This clinic is run jointly by Erie and Northwestern University's Medical School. It is staffed mostly by medical students from that school and is open two times a week. About 50 patients are seen in those two clinic sessions. It is a free clinic and the students indicated that some patients attend it because they have been rejected by other clinics, particularly because they are unable to pay for care. The students felt the clinic's program was limited and needed to be extended and enlarged. They were critical of the attitudes of the staff of the house insofar as the community was not, in their view, sufficiently represented or involved with the planning of any of the social welfare or health programs. They thought the community had very little to say about the programs currently available at Erie House or about what programs that might be more responsive to their needs and initiated.

The students described their activities, as follows:

> * * * the project tried to meet some immediate health needs, e.g., discovery and treatment of parasites, teaching mothers [health] skills * * * developing awareness among the Spanish community of their health problems and encouraging cooperating in solving these problems. Stimulation of fellow professionals * * * to consider the community and their responsibility to the community.

The students believed that there were negative features to their presence and their work;

> * * * More pacification of an already apathetic community; leaving without adequate education as to where to complain and how to get action on problems; creating concern over inadequate health care and facilities without providing proper channeling for these concerns to the appropriate people * * *.

When asked what they would have done, using hindsight, if they were starting the summer project again, the site report said:

> We would reassess the priorities of the community and work with housing problems before moving to health problems. We would maintain the same long term goal of increased level of [health] in the community.

Individual students echoed these sentiments:

> I am pleased to report that the families I have contacted have been most receptive and listened attentively to what I had to say. Whether they were stimulated by what I said about diets remains to be seen and depends greatly on their being able to fit my suggestions into their incomes * * *

> * * * This is mainly because our first goals in life—better heath for instance—are not necessarily their first ones. (We have found that housing is several times more important than health in this Spanish community. * * *

The students assigned to Erie House were ambivalent about the project. A partial text of an essay which indicates this ambivalence sharply follows:

As long as we have a way out, we are not peers of the ghetto inhabitant.—by Sandi Berkowitz (Nursing)

* * * There is a huge cultural barrier between the Spanish and Anglo communities which perpetuates separation from the dominant culture and consequently denies the Spanish-speaking community access to power. This is racism. All summer I was torn between the knowledge that although unity comes from a group identity, power comes only after acculturation—in a sense, a giving up of ethnic values and group identity. For example, was I to encourage the community health facilities to hire for staff Spanish interpreters (therefore decreasing the community's need to learn the dominant culture's language, English,) or was I to assume that it was better (in terms of power access) not to encourage the hiring of interpreters (thus accelerating the acculturation process by forcing the people to learn English) ? Furthermore, I knew that the group of people with whom I was working was not even representative of the larger Spanish-speaking population. The group I became close with had already accepted much of the Anglo culture, as evidenced by their very participation in the white Erie Neighborhood House. So was I really changing anyone?

It's true that the health classes we sponsored may have taught some of the mothers skills, may have given them information with which to function more independently and more confidently. But the group we probably affected most was not the Spanish themselves, rather it was the group of health science students from Northwestern University Medical School who came to Erie every Thursday night to run a free clinic for the community. After a few early confrontations with the Northwestern people which did nothing but alienate them from our more community oriented ideas, the four of us in SHP calmed down, backed off and tried working with the Northwestern [students.] We planted seeds of question, pointed out workable ways in which the community could be involved in the clinic's structure without presenting a threat to the students' self-interest.

My guess is that any change which is was possible for us to effect in Northwestern's philosophy was because there at least, we felt we had a right to be talking. It was understood that we were their peers. Obviously, this was not, and could never be, true in the ghetto community. We should have known that as long as we have a way out, we are not peers of the

ghetto inhabitants. As long as we have that dime, we have no right to be talking to them.

When I am asked, then, what the value of this Summer's experience offers me convincing proof that as a health professional committed to trying to change the present health care delivery system in the United States, my first responsibility lies in radicalizing my own professional community.

* * * The ghetto communities will organize and radicalize their own people.

THE WEST SIDE

On the West Side of Chicago students worked in the West Side Medical Center hospitals (see Hospital Sites section), with community organizations; in neighborhood health centers and clinics, and in settlement houses. A few students worked independently in a special program dealing with drug abuse conducted by a church agency.

The West Side of Chicago is succinctly described by the SHP Area Coordinator whose report follows:

No one has any power over his environment.—
by Donna Karl (Nursing)

The West Side of Chicago is a massive land area populated primarily by poor, black people. Once a thriving, Jewish settlement neighborhood with wide, handsome boulevards and well-tended townhouses, it has become an overflow pond for poor blacks forced from southern farms for lack of work and pushed from other areas of Chicago by economically hind-sighted urban renewal. It has become a stagnant pool of wasted humans. And it stinks.

Twice the number of people live here now as the area was originally constructed to house. The population density in some places, for inance, is 150–250 residents per residential acre which compares to the Lake Shore Drive area, characterized by many high-rise apartment buildings. In some places it is over 300 per acre.

Education standards have deteriorated along with population change. Teachers who once taught "challenging" Jewish students cannot understand the anger and educational apathy of black children. And black children cannot understand the middle class, white approach to supposed learning about their poor, black environment. A vicious cycle thus creates and perpetuates itself.

The greatest percentage of residents there do not set health care at the same priority level as does the middle class. There are too many more pressing problems to be dealt with—like the clogged toilet that hasn't worked for 2 weeks, like a $125 rent payment for the three-room apartment without proper electricity, or like the son who got "busted" for being black and standing on a corner. All of these things indeed fit into health care if not medical care. But it becomes quite obvious why medical care facilities may not be freely used.

Health to many people on the West Side means functioning. The concept of preventive, sometimes diagnostic treatment services does not become a part of their thinking. Illness is when one can't work or take care of her kids or make it out of bed to the neighbor's house. Illness is when normal, routine activities are stopped. Health care is *not* fixing cavities or drinking a quart or milk a day or getting a Pap smear. It is going to the Cook County Emergency Room when the pain gets so bad you can't pull on your cotton socks, or when the baby is hot and shakes every once in a while, or the bleeding won't stop and runs down your leg.

Many people on the West Side used the emergency room of Cook County Hospital. Dangerously over utilized, it sees about 1,200 patients daily, 75 percent of whom are "seen and advised," i.e., seen and sent home without further treatment at that time. Many of the small hospitals in the area will not or do not take welfare patients. Physicians are generally old, or specialists, or foreign educated, or part-time, or leaving, or have already left.

There are however two OEO funded community health centers which are attempting comprehensive care to ghetto residents in a community-based, self-determining health center.

The West Side is not a community if one defines a community as a group of residents within one geographical area with similar goals and some degree of group identification. It is a transient, brewing mixture of people thrown together. Many came North in search of "the land of milk and honey" and green bread. Unable to cope with the disillusioning reality of Madison or Sawyer Street, their dream has become scraping together enough money to return "home" to the South. They don't have roots here. They merely float. And there is little interest in the urban affairs by which they see themselves hopelessly strangulated.

The streets are strangely surrealistic. (Searing breezes, brown and curl Hershey wrapper edges that blow the ashes down a side street and into the gutter.) People there cling to *things* for identification. A little girl holds her popsickle stick close. Old men play checkers. But no one has any power over his environment. And there is little organization within it. And people remain pawns of a power structure which serves only its own ends.

Students working this summer on the West Side were primarily attacking a common problem—the disorganization of a society that has been herded into this state of mind. With no power, people react defensively and refuse to be a part of the structure. They project apathy to outside observers. And it grows, nurtured on the manna of nonexistence, into psychological disorganization that stunts any community endeavor or collective action.

One team of students worked at the Medical Center YMCA, which is located on Roosevelt Road at the northern edge of the Valley (North, Roosevelt Road; south, railroad tracks, running from 16th Street on the east to 13th on the west; east, Ashland; west, Western.)

Their task was to examine the health needs of the Valley area and work with the "Y" in an attempt to meet these needs. The team was conceived and set up as a dual group—black and white, with each respective group doing its own thing. The medical students were to deal with medical aspects and the black college/high school students with the community aspects. For several reasons the plans as conceived failed. First, the two white students (medical) on the nine-member team appeared to dominate the project from the beginning and stifled others speaking out. The black students, not being from that community, were too inhibited to get into it. Prematurely and without true community contact, the group immediately began setting up a screening and referral clinic. The clinic objectives were to do a simple series of diagnostic tests for chronic diseases, e.g., hypertension, diabetes, tuberculosis, lead poisoning, heart pathologies, anemia, vision difficulties, etc. Their plan was to refer diagnosed patients to medical clinics, and also to use the data gathered in approaching the medical center to get more complete services for the people of the Valley, a hideously deprived area within walking distance of the medical complex.

At first the community was not included in the group thinking. The students having contact with the leaders of the "Y" thought that this leadership was that of the community and when these men spoke they were representing the community. In reality they represented the young, more militant section only. They seemed to alienate many of the older persons who also need medical care and representation in decisions made about such matters.

When the idea of community representation did finally filter into the student's thinking, the clinic had been physically set up. The students felt that until they could *give* the Valley residents something, these people could not organize. The assumption, in many ways fallacious, partially goes back to the white man's paternalism and need to give the black "native" something. The Robert Taylor Clinic on the South Side of Chicago was planned from the beginning by the community working with medical students, and thus avoided some of the pitfalls which seemed to be inherent in the medical clinic.

But one significant happening came out of the project. There were several meetings of many different people, each with a common in-

terest in the future of the Valley and the persons living there. Representatives from the Halsted Urban Progress Center, the Circle-Maxwell YMCA, the University of Illinois, the Medical Center YMCA, and the community (six community ladies) all sat down and discussed the future of the Valley and how it could be shaped now by community intervention. The meeting demonstrated that, given the opportunity the extremely poor, black community can be interested in itself and its future. The medical people associated with the clinic now have the job of helping to educate the community about its health rights so that it may become more sophisticated and articulate concerning its medical rights and demand these rights.

The clinic is quite limited and its services inadequate. If further community activity does not continue, it will have been a failure. It will have been only another in a series of "summer things" that ghettos are the victim of every June to August. But it has the potential, having organized a community health committee, of activating the Valley and helping it grow into a community.

Spanish-speaking people live in the same disorganized kind of apathy as many black communities.

To deal with this problem a team of health science and Spanish-speaking high school students worked at Howell House (neighborhood service center). Their work concentrated within the realm of welfare recipient rights and organization around this issue. They worked with a leader of the Latin American Defense Organization who has had a degree of success in organizing Spanish-speaking people on Chicago's Northwest Side. The ultimate goal is forming a permanent welfare recipients' union in the Howell House area for Spanish-speaking people there.

The community in that area is composed of primarily Spanish speaking but also a small number of older Czechoslovakian residents who have remained in their life-long neighborhood, and a few blacks from across the railroad track (the Valley area). The people there are marginally poor, e.g., there are many second-hand and wholesale stores. People have enough to buy used furniture but not enough to buy new. Most go to Cook County or Mother Cabrini Hospitals with the distinct emphasis on the former. Among 38 physicians in the area about half are GP's, 35 percent are over 60 years old, and 50 percent were educated outside of the United States. Residents complain of much exploitation, high medical fees and drug charges. But no one does anything about the conditions. Many people in this area, being within a marginal income bracket, are ineligible for MANG but do not have enough money for medical bills above and beyond their normal living costs.

Students working in this community did a health survey of the types and numbers of medical problems facing people there and how they see, understand, and deal with them. The data collected is going to be given to the community to use in negotiating with Cabrini Hospital to possibly set up a peripheral clinic in the Howell House area.

The two medical students assigned to the St. Leonard's Drug Abuse Program defined their experience primarily as educational, without a great deal of "direct" community contact. But their original goals were realized. Many preconceived ideas were destroyed. The "junkie" became a human being. The stereotypes fell away. They have been able to examine and evaluate their original ideas about "junkies" and modify them to more reality oriented ones. For them the summer has been almost pure learning and reacting and broadening of mind.

Students working in the tutorial program at the East Garfield Park Mental Health Clinic (a city board of health facility) dealt with the common problem of community disorganization at an early level—with grammar school remedial readers. Students at Lawndale Association for Social Health (LASH) participated more directly by becoming a part of the staff of this social-action agency dedicated to redirecting normal anger of repressed people into paths productive for them, to encouraging black consciousness, to promoting economic gains

through a co-op grocery store and trades training program. The students learned about community responses and how they as white professionals of the future could fit into the scheme of providing medical services to such groups of people.

The students involved in this project generally agree that their main accomplishment during the summer was not really in dealing directly with community disorganization but in educating themselves.

I would, however, object to the project in the future as it was conceived and implemented this summer. The Kerner Commission made it quite clear that the problems facing the ghetto are, in fact, based in the white, middle-class communities and the white institutions. The place for students, especially white students concerned about the black ghetto, is somewhere outside of those ghetto boundaries, working to help them "behind the scenes."

For 10 weeks I've looked and seen and tried to understand and to digest and to emerge with something tangible and significant. And now I'm tired. I've exhausted my thought processes. But I can say that for me the summer experience has been most enlightening. I came into the program this summer with the same idealistic misconception as last summer. I came saying that the ghetto had given me much last summer and that I was tired of testimonials about "How I changed" or "What I learned." I came saying that I had a debt to repay to the community and that I wanted to use this summer to repay it for my experience the summer before. But as I look back, I can see that again I have gleaned much more from the ghetto than I could have ever given or ever will. Again I've changed or been changed by my summer. It hs again been a summer of the SHO-w, with me the receiver.

But I have learned one thing; that is how to deal *with* communities and not *for* them. I have learned that they have as much or more to give me than I them, I have learned that it is a two-way street.

The Valley

The Valley is part of community area 28 (near West Side). Roughly, it is bounded by Ashland Avenue on the east (1600 west), Western Avenue on the west (2400 west), and by Grenshaw Street on the north (1100 south) and 15th Street on the south (1500 south). A relatively large proportion of the land is devoted to industrial use and railroad tracks criss-cross its southern and western boundaries. This factor, to some extent, has created a psychological, as well as a physical, separation of the community known as the Valley from its near West Side neighbors. Between 12,000 and 15,000 people live in this community. Four census tracts in the area, when enumerated in 1960, showed that each had more than a 90 percent black population. There is no reason to believe that this magnitude has changed except to become greater. The median family income, then, ranged from $3,828 for the tract with the lowest median to $5,014 for the tract with the highest median income. Two of its four tracts reported the percent unemployed of the male labor force as standing at 13 and 17 percent, respectively. It is not possible to determine whether these unemployment and income data have changed significantly from the 1960 census for this small area. One-third to one-half of the housing in the four tracts was classified as substandard. (*2*) No change appears to have taken place in this respect either since there has been no new building in the area and 8 years have elapsed with subsequent deterioration. This community is probably one of the deepest poverty areas in the city of Chicago. While it is not possible to refine the mortality-morbidity indicators for this small section of community area 28, these data for the entire area undoubtedly reflect the conditions within the Valley as well.

Community area 28 ranks in the first (the highest) quartile for all five mortality-morbidity indicators. This includes deaths due to influenza and pneumonia for infants and noninfants; deaths from cervical carcinoma; deaths due to unknown and ill defined causes and new cases of tuberculosis discovered. (*1*)

The students assigned to the Valley undertook the development of a screening clinic at the Medical Center YMCA "Outpost." A most

important question concerning the future of the clinic was raised by one of the students (Jon Trefil) in his final report.

> * * * The main problem facing the clinic is urban renewal. At our first meeting where we had gathered together all the community leaders we were asked how we, as representatives of the medical center, could establish a clinic when that same medical center was planning, in the next few years, to tear down the entire neighborhood and build middle class housing and thereby displace all the people living there. Of course we did not have any answer. But this pointed to the real problem. What is the purpose of building a clinic when it will be torn down in a few years. The problems that these people are really concerned about are not medical but where they will go once they are kicked out of their homes. They have several other problems which are more important than medical care such as good education for their children, getting good jobs, and the constant police harassment. Our medical commitment began to seem more and more nearsighted. * * *

A report describing the organization and functioning of the clinic follows for a more complete discussion of the students' work.

The clinic was converted from an old casket factory.—by Robert J. Tanenberg (Medicine)

When I sit down and think about S.H.P. and the summer of 1968, two thoughts come to mind immediately. First, I think of how working in a black community has enriched my life and rekindled embers of youthful idealism to meet the challenge of changing our socioeconomic system which perpetuates the ghetto through racism and bigotry. Second, I feel much satisfaction in the realization that I was part of a small group of black and white students whose labors bore fruit—a small but concrete step toward righting the many wrongs committed against the black man in America.

That step was the creation of a community health clinic on the West Side of Chicago. This clinic began as the back room of a YMCA building which was converted from an old casket factory.

How did this clinic come into existence? * * * three medical and six high school and undergraduate students met with the young black director of "The Outpost"—a branch of the Medical Center YMCA serving a black community * * * in the heart of Chicago's near West Side. Here we learned that this community, although only a few blocks from the world's largest medical center, had no permanent health facilities (with the exception of a few private doctors). The director's answer to our question of what the community needed in the way of health care was, "everything." Thus, given a free and supportive hand from the YMCA we decided to build a medical clinic.

We could not operate a complete treatment clinic * * * but we could run a screening and referral clinic where medical students could do simple diagnostic tests under guidance of a physician, and then refer patients to a hospital. Thus, a person off the street could come to the clinic and undergo a 15-minute examination by a medical student.* * * If a chronic disease was suspected, he would be personally assisted to a hospital for confirmation and treatment. The screening would be provided at no cost and treatment costs would be on a sliding scale with welfare recipients having free treatment.* * *

Our problems, and they were numerous, can be considered as those involving medical know-how and equipment and those involved with "catalysis" of the community. In essence we came a long way toward solving the former and fell far short in tackling the latter. Contacts were made with a medical supply company and an examining table and scale were donated. A valuable contact with the Preventive Medicine Department of the University of Illinois enabled us to borrow another examining table and scale, two electrocardiographs, a spectrophotometer, and other medical supplies.

After a week of painting, scrubbing and

other types of hard labor, we placed our supplies in the room. Sheets hung from wires partitioned the room so that there was a general admitting area where case histories could be taken and [there were] two examining rooms. Meanwhile, several doctors had been contacted and we had standardized our screening procedure. In brief, we were doing simple urine, blood, and physical tests for diseases such as diabetes, anemia, heart disease.* * *

We mimeographed a form for each patient which contained questions for a case history, a list of medical tests with room for results and a legal release form signed by each patient or his parent, if under age. The medical students learned the use of the instruments from a lab technician and, in turn, taught the high school and undergraduate students how to take the various tests * * * [there were] lectures on the body and the diseases for which the clinic was screening.* * * Contacts were made at two hospitals so that our patients would have some priority.* * * Many doctors were contacted and one volunteered to act as a permanent medical adviser to the clinic. Essentially, we were [now] prepared as far as the medical aspects of the clinic were concerned. Now all we needed were some patients.

The Student Health Project incorporated the idea of including black high school students as interns into the program to act as liaison between the white medical students and the black community. Thus, we had hoped that our interns, along with two black undergraduate students and one black medical student, would go out to "their" community and bring people to the clinic. Unfortunately, these students, although black, were not from the community [the Valley] and were therefore strangers to the people we hoped to serve.

Nevertheless, flyers were distributed and community leaders were approached to announce that the clinic existed and would be open two evenings a week. This brought some response and we began testing. The YMCA arranged for us to test * * * over 100 children from a summer day camp.* * * We arranged for the Chicago Board of Health to send a doctor to the clinic once a week for lead poisoning tests. We also arranged for an agency to skin test area children for tuberculosis. We attempted to contact infant welfare stations to refer * * * for vaccinations. We unsuccessfully tried to get a chest X-ray [unit] stationed at the "Y."

Despite these efforts, the community response was poor. We next tried to motivate the community by forming a community health committee. More flyers and personal letters were sent and finally 20 people from the community came to the "Y" and we talked about health problems and the clinic. Many ideas were brought forth, a president was elected and plans were made. After a second meeting, the committee was for all practical purposes nonfunctional, yet its existence was necessary since it symbolized * * * the clinic belonging to the community * * * it was the first step of S.H.P. [in] fading out of the picture—an original goal of the group.

Attempts to publicize and promote the clinic included mailing of letters to all adult residents in the area; dedication of the clinic; and other methods, all of which met with limited success. Probably the method with the greatest potential was word of mouth * * * from treated patients. * * *

In order to insure that the clinic would continue in the fall, the medical students enlisted the help of the student AMA and other students of the medical college to volunteer 1 or 2 hours a week. When word came that the University of Illinois might build a modern facility in the community, plans were temporarily suspended, and it is presently hoped that all medical students will * * * have an opportunity to work in this community clinic.

If they do, then hopefully, others like myself will commit themselves to the cause of better health care—not only for the wealthy but for the poor too, since health care is not a privilege, but a basic human right.

Pilsen

Howell House is a settlement house administered by United Christian Charities Service

and is located at 1731 South Racine. Predominantly now a Spanish-speaking community (most Mexican, but a small number of Puerto Ricans as well), the area is also home for older Czechoslovakians and some Negroes. It was originally known as the Pilsen Neighbors so named by the Czech immigrants who settled there earlier.

The SHP team consisted of two health science students and two Spanish-speaking high school interns who live in the community. Their project included a survey of community health needs; participating with the Latin American Defense Organization in working with welfare recipients; and assisting individual families on welfare in securing health care.

The major report of their project concerns their experiences with the health care survey in Pilsen. A summary of the students' report describes this activity, and follows:

Health Care in Pilsen.—by Joseph Enderle (Intern), James McCulloch (Medicine), Jose Molina (Intern), Lewis Resnick (Medicine)

When our group of medical and high school students was assigned to Howell House by the Student Health Project for the summer of 1968, we felt a need to do something which might be relevant to the community. Our purpose in being there was to somehow improve the health care of the neighborhood. We thought that, logically, in order to improve its health care, we should first determine the nature of the health care facilities in the area and then find out what kind of health care the people of the area were receiving.

In answering these questions, we found that Pilsen, the area in which we were working, was a zone 2 (intermediate type) poverty area with a population of about 30,000. The area is now predominantly Mexican and Puerto Rican although there are still remnants of its original eastern European population and a fairly small Negro population. Most of the people living there are lower income workers and there are a good number of welfare recipients also. The housing is for the most part old and in various states of disrepair—for all practical purposes, no new construction has been done in Pilsen for more than 50 years.

This area, with a fairly large and heterogeneous population, has no hospitals located in it at all and only one recently established community mental health center located in a storefront. The one infant welfare station which used to serve the area was moved out a few years ago. We found that there were 27 private doctors in Pilsen, of whom only 17 practice in Pilsen full time. More than half are foreign trained, six are over 60 and six have been out of medical school for 30 years or more.

The 1965 report of the Chicago Board of Health recommended that community health centers be set up in each of the 24 poverty areas in Chicago. To date, two such centers have been set up in some of the worst poverty areas of the city. Our impression was that since Pilsen was located in a poverty area of the lower West Side and since the existing medical facilities seemed to be fairly sparse and relatively expensive, perhaps a community health center could be established in the area to its great advantage.

We were aware that, given the existing political and economic conditions in Chicago, no such center would be started unless significant pressures were brought to bear. Since we ourselves could not organize the community to form such an interest group in one summer, we thought that perhaps we could function by gathering information to be used by any such groups when they did form. To do this, we made a survey to assess the health needs of the community. Through this, we thought we could find what kinds of health care the people of the area were receiving and what their health needs would be.

The questionnaire we used was taken primarily from one developed by Philip Rushing, Student Health Project Research Director, although we felt a need to modify and add to it slightly. It consisted of 48 questions, the results of which are presented in the next section.

We talked to 150 people during the months

of July and August, usually on weekdays between the hours of 10 a.m. to 8 p.m.

Our interviewing was done in the Pilsen area, from Ashland Avenue on the west to the Chicago Canal on the east and from 16th Street on the north to 22d Street on the south.

Our method of selecting people to be interviewed can only be described as chance and haphazard. We would walk through the streets of the area and approach anyone we saw who was out on the sidewalk or on their front porch and appeared not to be doing anything pressing at the moment. We would then present ourselves and ask permission to interview them in something like the following manner:

> Good afternoon, Sir. Perhaps you could help us, I'm a medical student working this summer at Howell House. Because I'm a medical student, I'm interested in the medical facilities in this area and the way in which people who live in this area receive their medical care. What we're doing is making a survey, asking people questions such as if they have a family doctor or what hospital they use. We were wondering, would you mind if we asked you these questions?

Using this approach, only 10 to 20 people declined to be interviewed. Our reasons for not using a more rigorous sampling procedure were our inexperience and our reluctance to engage in house-to-house canvassing. Because of this, our results may not achieve a rigorous definition of statistical accuracy. However, we are of the opinion that the people interviewed roughly comprise a representative cross section of the people living in the area. Since our interviewing teams were for the most part bilingual, both English- and Spanish-speaking people were included. Also, when the interviewing was done, we made an attempt to cover all the streets in the area fairly equally. Although many of our respondents were women between the ages of approximately 25 and 50, our sample included both men and women, the elderly and some older teenagers.

The interviews were kept anonymous to encourage freedom in answering questions. For similar reasons, no socioeconomic information was gathered. Such studies have been done in the past and our interest was only in building a picture of the health care needs of this community.

Like the poverty level of the area itself, the results of this survey seem to be intermediate in nature. Pilsen residents (interviewed) are by no means suffering from a complete lack of medical care; an overwhelming majority (82 percent) are receiving some sort of medical attention during a year's time. On the other hand, there are definite indications that the health care is not all that it should be.

Almost one-third (30 percent) of the people interviewed had no family doctor and thus were dependent on public and private institutions along with occasional visits to neighborhood doctors for their primarily crisis-oriented health care. This means that carefully supervised followup care would probably not be available to or used by this group to any large extent.

In addition, almost one-fifth (18 percent) of the people interviewed are not receiving medical attention of any sort.

This would seem to indicate that while most of the people interviewed receive some sort of medical care there is a significant group of people whose medical care is vastly inadequate. If we ask why this group is not receiving adequate health care, we seem to find that one of the causes is, not unexpectedly, that of poverty. Previous studies (1965 report of the Chicago Board of Health and a study done by the 1967 Student Health Project, among others) have shown that poor health care is associated with poverty, and even this study, which did not specifically concern itself about socioeconomic problems, illustrates some relationships between inadequate health care and poverty.

The reason given most often for why people didn't have family doctors, why people didn't go to doctors when they had medical problems, and why people didn't go to dentists when they had dental problems was that of money. Also, in their choice of hospitals, the most fre-

quently used were Cook County and other comparatively free clinics such as those at Presbyterian-St. Luke's and Illinois Research and Education. Even in an important matter such as emergency care, the hospitals which were used followed the same general distribution. People who used Cook County and other such hospitals for their emergency care reported that they went there because these places wouldn't charge them and implied that they couldn't afford to go any place else. Even when faced with the prospect of waiting for up to 5 hours which most people considered unfavorably, more people went to Cook County Hospital for their outpatient visits than anywhere else. Thus we can see that for people in Pilsen as well as in other places, poverty seems to have a decided influence on the choice and amount of medical care. An alarming consideration in relation to this is that most of the complaints for which 28 percent of the people did not consult doctors were or could be quite serious. This is a group of people, therefore, who need prompt medical attention but are not getting it.

Another aspect of the area's health care is the way in which Pilsen residents utilized medical services. Although 73 percent said that a yearly checkup was necessary, only 58 percent actually had one. And of the visits that people of the area made to doctors for any reason at all, only 28 percent were for checkups. From these results it would seem that, although the yearly checkup is important in theory, in practice people only go when something serious actually occurs. It is this kind of crisis-oriented health care that is one of the characteristic features of the inadequate health care received in poverty areas.

Another important aspect of the health care picture in Pilsen is the apparent inadequacy of its existing health care facilities to provide for the total needs of the community. To receive their ordinary medical care, almost one-half (48 percent) of the people interviewed went outside the Pilsen area. The picture is even worse in regard to emergency care where fully 58 percent of the people had to go outside the area. In addition, more than one-third (37 percent) of the people made use of outpatient clinics which of necessity caused them to go outside the community since there are no hospitals in Pilsen. The average outpatient clinic visit required a 40-block round trip and about a 1 hour wait at the clinic. According to these measures, more medical facilities would thus seem to be indicated.

But there are other measures which also deserve attention. In relation to dental care, more than half (57 percent) of the people interviewed had not seen a dentist in the past year, even for a checkup. In addition, one-third of the people interviewed had dental problems in the past but had not gone to a dentist. When asked why, lack of money was reported to be a prime factor by most of the people involved. In a casual search through the telephone book, we found only 10 dentists practicing in the entire area. This seems to indicate a severe lack of dental services and dental care in the Pilsen area and appears to be one of the more pressing health needs of the community.

In relation to mental health, it is fortunate that the Pilsen Mental Health Center has been established. We found that 30 percent of the people interviewed reported that they had had some sort of nervous (emotional) disorder at some time. About 10 percent of the people interviewed reported having emotional disorders at the present time, and another 5 percent reported emotional difficulties within the past year. This seems to be somewhat higher than the national average one out of every 10 Americans and, if it is a valid figure, might be due in part to the conditions of poverty in the area and the conflict arising out of rapidly changing cultural backgrounds. A similar incidence (32 percent) of emotional maladjustments was reported for children in the area. When asked what they would do if faced with an emotional problem in themselves, only 47 percent of the people interviewed would see a doctor. Of the people who actually had an emotional disorder, about the same percentage (44 percent) actually did see a doctor. Of the parents who reported having a maladjusted child, only 28 percent sought medical attention. This is probably not a significant difference, however, since at least 46 percent of the parents attempted to in-

tervene somehow in the child's problem, including medical care. Thus, there seems to be a definite mental health problem in Pilsen and it is fortunate that it has its own community mental health center to deal with it.

Perhaps the most significant result, however, was the overwhelming 91 percent of the people who voiced their desire to have a community health center established in the area. Most of these reaffirmed that a community health center was badly needed. Repeatedly, the comment was made that it would help the people of the area and a few were in favor of it only if it did and only if it were inside the Pilsen area itself.

In summary then, it seems that: there is a significant number of people who are not getting full health care, one of the principal reasons being its relatively prohibitive cost for them; a good number of the people in the area receive their health care in a crisis-oriented fashion, rather than allowing for more thorough, followup types of care; and emergency and dental services are especially deficient, causing most of the people either to go out of the area, for emergency care, or not have any, in relation to dental care.

As our recommendation, then, these findings would lead us to believe that a community health center, located inside the Pilsen area, would act admirably to furnish all these additional services at costs low enough so that all would benefit.

Lawndale

The area known as Lawndale is actually two community areas; one is North Lawndale, the other is South Lawndale. They are community areas 29 and 30, respectively. No two communities could be more different even though they are geographically contiguous. North Lawndale is considered a zone 2 poverty area; South Lawndale is not a poverty area. North Lawndale is more than 90 percent Negro while the other is more than 90 percent white.

SHP teams worked in North Lawndale and this report will deal only with that community area, No. 29.

There are about 125,000 people living there. The median family income in 1960 was $4,981; 10 percent of the male labor force was unemployed; 25 percent of the families had incomes of less than $3,000 per year; 14 percent of the housing was substandard. (*2*) There has been virtually no new construction in this community since 1930 (when the population was about 112,000) with the exception of a small Chicago Housing Authority unit with 136 apartments. (*3*) North Lawndale was in the first quartile (the highest) ranking for all of the five morbidity-mortality factors. (*1*)

Martin Luther King, Jr. Neighborhood Health Center.—The Lepper-Lashof report (*1*) issued in 1966 recommended that 24 neighborhood health centers be established in the poverty communities of Chicago to provide quality health care to defined populations of these areas. To date, only two have been established and the Martin Luther King Center is one of these.

Two health science students and three high school interns were assigned to this site. They worked in the day-to-day routine of the health center and with the community health aides so they had some exposure to both the center and the community which it serves. The students worked individually by conscious decision so they could function best in assisting in the work of the center and still work in areas of their particular interests. The three high school interns plan to continue working with programs during the coming year.

As stated so commonly throughout most of the reports the students felt that they had been the recipients of the benefits from the summer's experience. Selected quotations indicate this.

Raymond Zablotny a health science student, said in his midproject evaluation,

> My main goal in the SHO project this summer is to learn: * * * When I speak of learning I do not necessarily mean from the careful collection of statistics but rather knowledge from the mouths and lives of the peo-

> ple with whom I come in contact in my work. * * *
>
> I have * * * made a special effort to try and understand the problem of community control of the center. I have spoken for many hours with * * * the community organizer of the Center, and have attended meetings of the Community Health Council.
>
> * * * I think my role as a student in this site is one that will enable me to become a better, more aware health professional.* * *

Unlike some of the criticisms of the summer project which revolved around difficulties in relationships between health science students and the high school interns, health science students at this site did not have this experience.

This seemed to be the feeling of the high school interns as well since in describing what all five students thought were the short and long term positive effects of the project, their report said,

> We have helped things to run a little smoother in some areas, to actually get a little more done, and to add to the convenience of the patients. * * * Our chief contribution here seems to lie in the area of human relations and a rather good spirit of working and being together.

Lawndale Association for Social Health.—Two health science students and two high school interns joined this 3-month-old privately subsidized agency, staffed with psychiatric and social work professionals. A new concept about some forms of mental illness is embraced by this agency, i.e.,

> * * * The concept that mental illness is often * * * a normal, understandable adaptation to an intolerable, stifling environment is a strong assumption at LASH. And so this Association is unique among mental [health] institutions in that it deals with the environment of the patients rather than merely the symptoms of that environment as manifested by the patient. LASH treats people in their usual setting, and in doing so attacks the environment *. * * The attempt is not made, as is usual, to remove disturbed people from the stressful situation and treat their problems in an alien context.
>
> Instead, the orientation of LASH is to cure and prevent mental illness by helping people to alter those environmental conditions which contribute to their mental illness. * * *

This description of the agency's orientation is by one of the medical students, Howard Fenn. His reaction to his site assignment is presented in the following essay.

I see myself in the role of an observer and a changer.—by Howard Fenn (Medicine)

When I began the Student Health Project of 1968, the goals I foresaw for the summer were directed toward two areas: myself and the community. With regard to the community, I envisioned the possibility of perhaps slightly altering the sense of futility among the populace. The despair and hopelessness so apparent in a poverty neighborhood are linked closely with so many other terrible characteristics of a poverty zone: high unemployment, low educational level, political disenfranchisement, alcoholism, and substandard living conditions. It is true that a partial cause of all these factors is the capitalist system and a disinterest of the establishment toward the poor. However, also at fault in perpetuating these conditions is the mental state of the inhabitants of the poverty area. In order to alter the physical health of these people, which is hampered by the poverty state in which they live, the mental health must also be improved. And this was my original goal for the community: by attempting various self-help projects, the hopelessness and despair present would be alleviated, improving mental health and thereby working against the poverty conditions. Unfortunately, the progress I have accomplished in this area has been minimal. But the goals with regard to myself are being reached through my attempts to alter the community.

The goal for myself has always been to learn more about the "culture of poverty," the conditions which bring it about, and what methods there may be too combat it. This I am slowly becoming acquainted with.

The site at which I am working coincides well with my projected goals for the summer. The Lawndale Association for Social Health is committed to the concept that the mental health of the Lawndale community can best be improved through direct social action taken to better conditions in that community. Several projects are already underway in order to effect such betterment: adult education, a cooperative business, vocational training, and psychiatric workshops are just a few of the projects.

I have been engaged in helping and observing several of these programs. In addition, I have been involved in a tutoring program in the local Lawson Elementary School, which is gaining speed. I have, with the help of a clinical psychologist from Madden Zone Center, been formulating a course in psychosocial development to be perhaps presented to possible dropouts at Farragut High School. This program is to be initiated on July 29, on an experimental basis.

While engaging in these efforts I have indeed learned much of the neighborhood problems and the possible solutions. But as for directly affecting the people of the community I must admit that this gain is not visible. However, it is hoped that in the next few weeks of the summer these projects will begin to take hold and continue as permanent scenes in the neighborhood. The psychosocial development course, in particular, will be initiated in this last half of the summer and will make a continuing contribution to the mental health of high school age youngsters. In addition, my goals with regard to myself will be attained as I see projects take form and achieve small effects on the community.

And this, indeed, is my major role as a health student in the community. For at my present status and educational level, there seems to be little effect I can have on a deprived community. But in my attempts toward change in the neighborhood, I am gaining the skills and knowledge for future, more successful attempts, when my higher academic level will also add to my degree of effectiveness. So for the present, I see myself in the role of an observer and a changer, with the emphasis on the former so that eventually my ability in the latter will be increased.

Drug abuse.—Elsewhere in this report we have occasion to note the frequency with which SHP teams felt their 10-week effort had produced little change or had "failed" entirely to meet the goals they had set. This reaction was less evident where teams were taking up the unfinished SHP projects of the previous summer. Following is the report of a student who returned in the summer of 1968 to continue work she had begun in the Summer Health Project of 1967.

Joint Community Program on Drug Abuse.—
by Jeanie Snodgrass (Nursing)

As this summer draws to a close and the project ends, people are going home, back to school or whatever; most are leaving Chicago behind—leaving the project with an education and with observations they'll never let slip their minds. For me the 10-week project (my second affiliation with the SHO Summer Project) was really a renewed beginning, or maybe just a continuation of the commitment I'd found the summer before.

Last summer I left the project after 10 weeks, having made not so much as a minimal contribution to the health center where I had worked: of course I gave nothing to the larger community of Lawndale.

I did come away pondering many new thoughts, my world of experience and exposure much expanded, which was of no lasting value to anyone but myself. I felt that I had taken something from the community, leaving nothing of value behind; what's more I had used other people's money to do it.

I couldn't leave with a record like that. That summer only whet my appetite for community involvement, and I just couldn't leave—so I

stayed. I continued to work with the preceptor at the health center, who was in the process of planning the mental health services for the center. I took on the role of his "Girl Friday," and I learned more and more.

I became interested in one particular mental health problem that was plaguing the Lawndale community as it does so many other communties; this was the problem of drug abuse among the youth. I undertook an exploratory study to find out the true scope of the problem.

During November and December I visited youth agencies, law agencies, health facilities and many individual persons serving the Lawndale area. I was taken by surprise by the findings that the problem was apparently so great, yet no one really knew how great, and no one was making any effort to curb or deal with the problem.

With the results of this study, my role for this summer became more clearly defined as I discussed the findings with many persons—some of whom I had interviewed during the study—involved in youth work on the West Side.

By June I had several people interested in doing something about the problem. No one had yet defined what type of action should be taken, but gradually throughout the summer a specific program has taken shape. This had been done through combined efforts of over 40 community agencies who have banded together for the first time to combat the rising problem.

At the present time, the actual program is about to begin, training programs for the police and youth legal agencies, and the treatment center workers taking place in early October. In the total comprehensive program, we are involving over 40 community agencies, 45 schools of five school districts, and 10 youth "Treatment" centers, plus the police Youth Divisions of four districts, and the juvenile courts. Actual referrals of youths involved in drug abuse will begin November 1.

I feel that my first summer was not wasted now, for it laid the foundation for me for a whole future's lifetime work, and has truly been the catalyst for a program which is a much-needed contribution to the community, and a contribution with long-lasting effects. I will be continuing my work with the program for the coming year, as the paid "Coordinator" of the program; but within one year I hope that the program will have become a successful integral part of the programs of each agency and institution involved.

The ramifications of this program extend far beyond the treatment of youthful drug users. The program involves communication and coordination of activities among more than forty agencies, raising the level of interaction and intercommunication to a new level.

Needless to say this work has defined a future role for me; more than that, it has clearly uncovered a new way of life for me. I feel now, too, that I have paid back the money and experience debt I had accumulated that first summer, and I'll be continuing to repay it the rest of my life.

St. Leonard's House

This site is a halfway house administered by the Episcopal Diocese of Chicago. The staff includes physicians, psychologists, social workers, and priests. Its purpose is to act as a rehabilitation and support center for ex-convicts and for narcotics addicts. It is located on Chicago's west side but accepts guests from all over the city. However, it is closely related to the community in which it is physically located; namely, the Mile Square. There is an advisory council composed of leaders from this community as well as therapists and others from the addict community.

Private contributions, church charity funds, and Federal moneys support the work of this agency. A special program for rehabilitation of narcotics addicts is funded by the Office of Economic Opportunity.

The agency is currently planning a program focused upon juvenile delinquency and drug abuse. It was in this area that the two students assigned to this site did the greatest amount of their work.

They interviewed directors of about 20 West

Side agencies. Their intent was to determine what kinds of programs, if any, these agencies sponsored that had to do with juvenile delinquency or drug abuse.

> * * * We found that there are many and varied programs for juveniles on the West Side, all of them at least indirectly affecting juvenile delinquency. However, there were very few programs which were directed specifically to help kids who were in trouble with the law, though most of the programs took care of these cases when they came across them.
>
> As far as drug abuse was concerned, all agencies were aware of drug use of one kind or another, but almost none had programs of any kind on drugs, and almost all stated that they would like to know of a referral agency or resource for further information on these problems. * * *

Their learning experience was again stressed, as is common throughout the report:

> At two of the agencies we visited, we encountered some hostility which resulted in very poor communication * * * our interviews with these two agencies were "good for us" in that we were able to get a broader view of the spectrum of attitudes in community agencies, especially their feelings and reactions toward white liberals. * * *
>
> Short term effects on ourselves consist mainly of broadening our outlook on the problem of drug addiction, and equally important, becoming acquainted with the people and their feelings in the ghetto. In the long run, the experience of this summer will help us to evaluate both our capabilities and our desire to work in community medicine. If we should eventually end up in community medicine, we will perhaps be able to make a better contribution in light of the insight gained this summer.

The impact of the site assignment on one of the students is beautifully expressed in the following essay.

* * * *I did not know my own ideas.* * * * by Emily Gottlieb (Medicine)

It seemed perfectly obvious to me: all these emotional arguments presented by the more militant speakers at the orientation session were nothing more than illogical harangues directed at antagonizing the white audience. I was all for civil rights and integration, but the leaders of SHP seemed a little too enthusiastic in their desire to be liberals—these speakers were one case in point, another being the pictures of Malcolm X which decorated the meeting hall. Granted a small minority may think these militant ideas, but I know that it certainly didn't speak for most Negroes. Anyway, these militants were so illogical and disorganized, they would never be able to collect any sizeable following, much less accomplish anything concrete, since their modes of thinking were so obviously immature.

The interns I met at orientation were of a more sensible nature, able to think in terms of Negroes and whites working together in a brotherly fashion within the ghetto to help Negroes better themselves. They were certainly more mature in their ideas than certain of the speakers I had listened to—and since they are the youth of the ghettos, do not they speak for the future? I was sure most of them didn't really like Rap Brown any more than I did. He is all right, but a little too radical, and he doesn't seem to want any of the assistance offered him by white liberals today.

The above is an approximation of the attitudes with which I began the summmer. They were not changed by the few days of lectures during orientation. But perhaps the orientation provided the initial confrontation which was to force me into a reevaluation of my attitudes throughout the summer. As I rode home from Camp Reinberg, I felt that, on the whole, I was in tune with the young Negroes of today—that I understood them, and that we shared common goals. Yet, there were some disturbing ideas that came to mind occasionally: some of the speakers seemed very hostile toward the

white liberal in general, and suggested that whites had no business in the ghetto. I was able to dismiss these memories easily, however, when I thought of the many people I had heard who had reinforced my own views on the problem of discrimination—I didn't let the words of the militants stay in my mind long enough to bother me.

My summer assignment was to work at St. Leonard's House, a halfway house for drug addicts and ex-offenders coming out on parole. St. Leonard's is located on the near West Side of Chicago, just off Madison Street. Many of the buildings in the area were gutted by fire last April, but they are still "inhabited" by addicts, winos, and little kids during the day, sitting on the doorsills or empty window frames, watching Madison Street move by. A layer of pulverized glass covers the sidewalks and trash is everywhere.

Storefront businesses that are still in operation are fortified by iron grillwork. The local Walgreen's has replaced all its plate glass windows with obviously durable paneling. The schools in the neighborhood are easily recognized by the large number of broken windows. Occasionally, there is a vacant lot, of bricks and rubble, with a sign designating it as part of some plan for urban renewal, Richard J. Daley, mayor. Two blocks from St. Leonard's is a very large, dirty building that exudes dust, the public aid office.

At St. Leonard's, I was introduced to the staff members who are black and white. On my own I got to know most of the people living at St. Leonard's most of them black. My coworker and I both were astonished at the intellects of the people we met—people who had been on drugs, or who had been doing time for armed robbery. And reluctantly we realized and admitted the subtlety of our own racism—that we were surprised that blacks were intelligent.

One man, I shall call him James, we got to know and like very much. James had just kicked his habit a few weeks before we met him. He could talk for hours on all sorts of topics, ranging from Malcolm X to jazz to Operation Breadbasket to the Communist Party. Within a few days, I discovered an interesting thing happening to my conversations with James; I was scraping the ground to make this man like me, but the way in which I did this was quite fascinating. Knowing James to be of militant leanings, I mouthed to him the very ideas which I had heard at orientation, and with which I had so much disagreed. I do not know whether James believed me, but for a while I succeeded in convincing myself.

Soon enough I realized what I was doing, and for the first time, I admitted that I did not know my own ideas, much less understand those with which I disagreed. It is difficult to describe the subsequent process in which I reevaluated my opinions, and at the same time sought to gain insight into the ideas which I had thus far rejected on the premise that they were insignificant. Given the ideas to which I had been more than superficially exposed at orientation, I was able to appreciate and benefit from various experiences at St. Leonard's.

There were several instances in which I felt I was discriminated against because of the white color of my skin. I once thought I had been able to talk meaningfully with a woman living at St. Leonard's. But the next day, I overheard her talking with a person of her own race (black), and she seemed a different person. What I thought I had been talking to was an act she had contrived because I was white. Whenever this type of thing happened, I felt very depressed. At the same time, I was beginning to experience, though on an extremely reduced scale, some of the frustration, even anger, over events determined solely by skin color. No longer did "the race problem" remain a rather intellectual phenomenon to be read about, and mulled over in discussions; it was real to me in emotional terms.

During the summer, I believe I was able to sense a feeling that hangs on everybody and everything in the ghetto. It is almost as if the ghetto is a forgotten part of the city. One sees the forgetters every day driving down Madison to the Loop—they never seem to notice what life lies between their jobs and their secure suburban ranch homes. What bothered me was a seeming apathy on the part of the people

in the ghetto—didn't they know that nobody cared? Why didn't they do anything and demand to be remembered? It wasn't apathy I saw—it was an acceptance of the ghetto as their only way of life. What had the black man ever seen to suggest that black men should expect more? Who has ever proved to a ghetto child that a schoolteacher makes out better in life than a good hustler?

The more I seemed to be learning about the ghetto, the more I realized that to understand the feelings of blacks, one has to be black. Perhaps I knew what it was like to be judged on skin color, but I will never know what it is to be judged on black skin color. Along this same line, I slowly began to understand black objections to whites in their neighborhood. First of all, whites had plenty to do in terms of cleaning up their own communities, spiritually if not physically. Secondly, the black man is tired of saying thank you to the white man for the few crumbs that are swept his way. Lastly, blacks are starting to throw off their warped self-images of second rate human beings, and are taking pride in themselves and their community—and it is they who will make the decisions about thmeselves and their community from now on.

I am repeating ideas probably already quite familiar to many, and even accepted by many —but they are reproduced here to illustrate my own change of attitude through the summer. I am grateful to St. Leonard's and the people of the neighborhood for enabling me to see the inflexibility of my original attitudes; and for having provided me with the opportunities to reshape my ideas, which, I hope, will continue to change and not stay fixed by disregarding any opinions contrary to my own as they almost did at the start of the summer.

THE SOUTH SIDE

Students were assigned to a variety of organizations and agencies on Chicago's Southeast and Southwest Sides. In addition to their experiences in several hospitals (see Hospital Sites section), they also worked with outpatient clinics, civic associations, health associations, community organizations, settlement houses and church-supported or church-related agencies.

Abraham Lincoln Center

This site is a settlement house which has been in existence for 50 years. It offers a wide variety of programs and services for all age groups. The community is serves is located in area 38, also known as Grand Boulevard. Its population is about 99 percent Negro and it is considered a zone 1 poverty area (greatest concentration of poverty). (*1*) About 83,500 people reside in the entire community area. The median family income in 1960 was $4,329 but 32.6 percent of the families had incomes below $3,000 per year; 12 percent of the male labor force was unemployed. (*2*) The community area was ranked in the first quartile (the lowest levels of health) for all five mortality-morbidity factors. (*1*)

There were three health science students and two high school interns assigned to the Abraham Lincoln Center. Their project goal was to help launch a community health committee. The team reported briefly. "It did not succeed," ascribing the failure to "community apathy," and predicting that, "no one else can succeed here."

Yet the essay that follows emerges as the most outstanding personal commentary on student's experience during the summer. It sums up the continual theme of "learning" for SHP participants, black as well as white, during the summer's confrontations.

"If you can't appreciate a toothpick, a yard full of golden lumber won't do you no good."
—by Roscoe Woosley, Jr. (Premedicine)

"Rocky?" * * * He was coming toward me with a huge blade now. He wanted, it seemed, to cut my throat and the razor blades he had used before weren't good enough. My skin has a number of long slits that are bleeding quite freely * * * "Rocky! It's 7:30" * * * He's advancing now. Slowly, every slowly, he moves with the blade raised high overhead. His black skin glistens with sweat. His face looks so hard and fixed it seems to have been carved from black ebony. His face is expressionless

save the slight hint of a smirk, eyes glazed, and not a twitch of nervousness. He stops as a cat stops before he lunges at his prey. He rushes * * * "Rocky GET UP!"

I abruptly but thankfully awoke and slowly climbed from bed. With a sigh of relief and twinge of remorse I vividly remembered last night's dream. Why?

What day is it? Oh yeah, today is Monday. The beginning of the week and work and mindful confusion.

I put my clothes on and went downstairs to wash up.

"See you later, Mom. Have a nice day at work."

"You too, Rocky, Eat a good breakfast before you leave."

"OK."

I turned on the stero to have a little music with my cold ceral. I should have fixed some bacon and eggs but I just didn't feel like cooking.

"Well, I guess I better get going. It's already nine o'clock."

The people have all learned the game everyone plays on the bus. Everyone keeps a straight, impersonal face so no one may hurt you, or think you're crazy, or make a pass at you. Everyone puts their masks on when they enter the bus. The sad part of this game is that even the young children have learned to play and in the morning when they get on the bus going to day camp they don the faceless mask of unconcern! Even more tragic to me is the realization that I too, have a mask, or is it a God-sent gift?

"Well the next stop is mine".

"Oakwood! Oakwood Boulevard, next stop."

I remember my first day getting off at this stop. Apprehension and the fear of physical harm cluttered and clouded my mind. I remember meeting the old man. He was a short, elderly, potbellied man. He wore a pair of old, faded purple, blue pants that shined from wear. His coat was black and white checked and grayed with dirt. He wore a light blue shirt, opened at the neck. His shoes were an old brown color and the heels were worn down so much they made him appear to walk with a rocking gait. His head was covered with a battered gray felt hat whose crown had been molded so much, it looked like it had collapsed from exhaustion. Beneath this hat was a warm face. His eyes were black and penetrating, but they held a warm glow as a coal holds fire. His eyes darted from me to the street as we walked toward each other on the sidewalk. When we met he stopped me and asked if I was in college.

"Was it that obvious," I thought to myself, I don't want to look like that. It wouldn't be too healthy around here."

I said I was and he told me to stay there. Then he told me something, he said: "Always remember, if you can't appreciate a toothpick, a yard full of golden lumber won't do you no good, son." He told me he had graduated from Fisk University in 1937. I wondered under what circumstances he came to live in this neighborhood.

I remember my first impression of the "houses." Some were painted in a vain attempt to make them presentable to society. Some were just left to die a natural death. Some of the people tried to keep the grass growing, if there was any to begin with, to give the old places some new life. One house, in particular, was nicely, but rather gaudily painted in my estimation. This two flat was painted blood red on the face brick from the roof to the porch and down the cement stairs to the sidewalk. The storm window frames, door and down the middle of the steps were painted a deep, mossy, moody green. It had a shiny new, aluminum storm door and window awnings, and the grass was green and rich. I liked it and silently complimented the owners that first day. As I look at it again today I get a sick, depressed feeling inside. Another house farther down the street caught my eye, also. It had no windows, they had been broken out, the door stood wide open off its hinges with at least six dogs lying in the dirt in the front of the house. An old black woman with big, gnarled hands, muscular arms and shoulders sat with a child in her arms on the wooden porch. I felt guilty the first day

because she turned my stomach. I couldn't look her straight in the eyes. I stepped up my pace with head bowed in order to escape her seemingly stone gaze. Today, as I walk down this street, I find myself moving at a slower more relaxed pace. I still cannot look her in the face but I know now why, and how, and I understand her. I feel no pity for her, just a deep understanding and a knowing frustration.

The center stands on the next corner. It's an imposing structure. My first impression was of a warehouse. It's red brick, dirty, old, and looks very tired.

The elevator doors opened onto the fifth floor and my office is room 5–B.

About 3 weeks after I first arrived there the telephone rang.

"Hello, Roscoe Woosley, Student Health Organization."

"Hi, Rocky, This is Mrs. Hill. I'm downstairs. I have something for you."

"OK, I'll be right down."

After what seemed to be an endless ride on the outdated, 5 m.p.h. elevator, "Hi, what's up."

"Well, Mrs. Parker, here came in with her four children. One got bitten by a dog last Sunday and she brought her here because she has no transportation or babysitter and the child's leg is swollen up, See?"

"Oooh damn! We better get her to a clinic. Let's go."

That went on for 2 weeks. Ron and I picked up 7-year-old Karen and took her to the clinic for rabies shots. Karen, as most girls her age, was a slim gamely child. Her face, though, was not the face of child of seven. She had a beautiful full face that contained an unnatural awareness. She, seemed more self-reliant and mature than other girls her age. She wore clothes that were too small for her and sometimes soiled but she was probably fuller of life than other children. On the fifth day, after we had gained her trust, she seemed to have lost her easygoing, Sunday disposition. She seemed troubled and we asked her what was the matter.

"I feel fine."

"Then what's wrong, Karen?"

"I don't want to go home right now."

A beautiful black girl with deep dark eyes and a razor-sharp mind would rather get shots than go home. There was nothing I could say to console her. Her younger brother lay crying at home in bed because the gnats and mosquitoes, so abundant in the dirty two flat apartment building where they lived, had bitten him so much he had broken out in hives all over his body.

"I'm hungry."

"Didn't you eat this morning, Karen?"

"I just had a sandwich before you came to get me."

My mother's words came racing back to me. "Eat a good breakfast before you leave." But I was too lazy to eat. What could I do? If I bought her anything she may realize the desperateness of her station in life because she was black. But would that be good or bad? Who knows? My lunch sat cold and untouched in front of me that afternoon.

"I want you all to start a diabetes program in the neighborhood."

"We want a clinic."

"What about all the children with tetanus that won't be admitted into school this fall unless it is cleared up?"

"The main objective of this project at this particular site is to effectively organize the community so that they may control their own lives."

"What are you doing here that KOCO doesn't already do?"

"You're just a fixture, you're not effective and nothing concrete has happened."

This is what was asked, demanded, and said to us by members of the Student Health Organization, the Concerned Parents Group of Ida B. Wells which consists of no more than 200 people whereas Ida B. Wells accommodates thousands, and other people who had been in the neighborhood for about 5 years. How could I organize or help organize any community

when I didn't have an organized mind. I didn't know what all the problems were, where they stemmed from, or how to effectively cope with them. I was unorganized and confused in my thought in terms of my identity, and in terms of what my role in life is to be. I didn't know why I thought the way I did.

In terms of benefiting the community, I was a total failure. In terms of myself and how the project benefited me, however, it has achieved one goal. It has made me aware and has made me change mentally.

I realize now and understand why I had that dream. I was afraid of my own people. I had been brainwashed into believing my people hated me and anyone else who tried to get ahead and, therefore, I feared them. What was not drummed into my head was that the only reason my people dislike others who tried to get ahead was because they seemed to always forget or disown their own kind. The fear the first day at work is now as understandable as the feeling of remorse after the dream.

The confusion my mind was assaulted by at the beginning of the summer has been conquered, I understand, now, the cord which joins together the old man on the street to the woman on the porch to the little girl named Karen to me and the rest of the black people. No more will I be able to think and act as the people in the gaudy house who disregarded their neighbors and their people. No more will I be able to strive to think and act as a white man. For now I know what besets my people, and how, perhaps in a feeble way, to help them and myself. Now I am able to understand the proverb that was told to me a black, persecuted old man. If you cannot appreciate the smallest thing or the seemingly smallest person, a whole college education with an infinite understanding of the universe is worthless.

How could I before, do anything to help the people in my site if I was as unorganized and as in need of help as they were. Now, at least, I am able to see more than before. The Democratic National Convention was also a revelation. I had not before fathomed the power Emperor Daley possessed. Now that some of the pieces are beginning to fit and a pattern is presenting itself, it is up to me and all black people to begin to try to put the puzzles together which are themselves. Then, and only then, may we advance. For me there lie other pieces to be fit together and now is the time to regroup and advance. Before this summer, all of this was unknown to me and I am deeply grateful to the Student Health Organization for making this realization possible. For with this realization and a great amount of determination and action there is hope and an answer for the "Karen's" of the world and all the "Classes of 37."

The Robert Taylor Homes

The Robert Taylor Homes is a giant housing project, the largest one administered by the Chicago Housing Authority. It is located on 92 acres of land between 39th and 54th Streets on State Street, running about 2 miles in length and two blocks deep. (*3*) They are high rise units, most of which are located in community area 38, just described; however, some spill over four blocks in community area 40. The parameters for 40 are similar to those for area 38.

The Taylor Homes have become a community unto themselves, isolated from the surrounding South Side. Even branches of schools operate in apartments within the housing project. It is an extremely young community with 20,300 of its 27,200 residents below the age of 18 years. The average number of children is 4.7 per family. (*3*)

The median family income at the end of 1967 was $4,860 per year and 48.7 percent of all the families were supported by one or more public assistance grants. Of the families with assistance grants, 75 percent were supported by the Aid to Dependent Children category. Racial occupancy is 100-percent Negro. (*3*).

Ten health science and high school students were assigned to work with the Robert Taylor Homes Health Committee and the Robert Taylor Homes Health Clinic. The former is composed of residents of the project who are concerned with health issues in their community. Mostly women comprise its leadership. The lat-

ter has been a goal of the Health Committee since its inception. Student Health Organization members have been working with the Health Committee since the summer of 1967 assisting them in attempts to open a Health Clinic in the Taylor Homes. The clinic finally was opened in the summer of 1968. Students participated in the opening and the staffing at first. However, the Taylor Home site was one of the most trauma ridden for the students.

The best description of the student involvement this summer at this site is their own report. The text of this report follows.

Taylor Homes Area Site Report.—by Pamela Osbourne (Nursing), Suzan Simons (Psychology), Grace Dammann (Social Sciences), Steve Rand (Medicine), Mary Anne Caswick (Medicine), Andrea Gay (Biology), Vincent Tornabene (Medicine)

In the process of writing this report, it became evident that the report could be written from any one of three points of view: that of the ladies of the health committee, that of the white health science students, that of the black health science students. In view of the constituency to which this report is directed, all students at the site agreed to write the report from the point of view of the white health science students. Student efforts in the Taylor story include two Student Health Projects (the summers of 1967 and 1968) and the efforts of the Student Health Organization during the intervening school year (1967–68). In this report the name "SHO (Student Health Organization) is used to include all the students who contributed to the Taylor story.

What drives a college student who really knows nothing about a black ghetto to enter that ghetto? "I want to help these people," said one SHO member who worked in Taylor Homes on the 1968 summer project. "I thought I could learn a lot," said another. With these attitudes and all the ignorance and paternalism behind these statements, SHO, in 1967, sought its contact with the Taylor community and ended up with the Illinois Humane Society which has an office in the Taylor area.

The Robert Taylor Homes, the largest public housing project in the world, are "high-rise concentration camps" (Dick Gregory) that pack 30,000 black people into a one-block stretch along 2 miles of South State Street. The city of Chicago built "Taylor Homes" with Federal funds during Mayor Daley's second term and *planned* into the project such defects as totally inadequate playground and recreational facilities, two small and often inoperable elevators for each building (1,100 people), and, most devastatingly, the swept-aside feeling that comes from being stacked into a 16-story prison. "Depressing"—that is the word most commonly used by people caught in Taylor Homes.

In June 1967 the one black and three white health science students of the Student Health Organization went into Taylor Homes and immediately saw that the Humane Society had little real contact with the community. They then proceeded to conduct a survey of the health needs of the community by interviewing about 40 parents at great length. The Taylor residents told of the lack of health care facilities in their area. Several mothers said, "I need a place where I can take my children when they are sick." After hearing statements like this the SHO students decided that it was possible to set up a clinic to serve the Taylor Homes area. The Infant Welfare Station at 47th and State Streets seemed to be a logical place where a Taylor mother "could take her children." The Infant Welfare Station, like all the Taylor Homes buildings, is owned by the ubiquitous Chicago Housing Authority. Taylor residents and other "project" people of Chicago hold a special resentment for the Chicago Housing Authority, their "keeper." Their justifiable rage seethes when a baby falls 13 stories because Chicago Housing Authority hasn't repaired a balcony fence, as happened again in September 1968. The Chicago Board of Health leases the Infant Welfare Station in Taylor Homes from the Chicago Housing Authority. This station, like the others in Chicago, does not serve sick children but only well babies who get routine checkups and immunizations.

At the suggestion of one of the SHO members, several of the ladies who had been inter-

viewed met at a local church and decided that they themselves could indeed improve their neighborhood health situation. They complained about their health problems to each other and asked why these problems existed. This was enough to motivate the ladies to form the Taylor Residents' Health Committee. They elected Mrs. Shirley Collins, one of the ladies present at the meeting, chairman, and they dicided to seek better health care through the establishment of a low cost clinic that would serve Taylor Homes and would be under their own control.

Now, 1 year later, that clinic is operating. The Taylor Residents' Health Committee controls the operations and there are finally no SHO people in any positions of authority. The doctors who practice in the Taylor area have met with the Taylor residents on friendly terms. The young men of the Taylor Homes, potentially the strongest power in the area, have forced changes in the structure of the Taylor Clinic. The removal of the white students, whom the Taylor ladies came to depend on, gives the Taylor Clinic a chance to be a constructive force in the black community.

The Taylor Clinic revolves around Mrs. Shirley Collins and about seven other black women who make up the Taylor Residents' Health Committee. Their determination overcame huge obstacles that would have stopped any average group of people—obstacles like a city that makes discrimination against the poor an avowed policy (i.e., the building of Taylor Homes), a history of calculated discrimination against black doctors that left them alienated from their own communities, and lastly the obstacle of the white paternalism of city health officials, hospital administrators, and SHO that fostered dependency upon white institutions and catalyzed splits among groups of black people.

On September 12, 1967, Samuel Andelman, then Commissioner of Health, said in a letter to Mrs. Collins, "We are glad to approve this request (to use the Infant Welfare Station), and we will look forward to working out the details with you at the time you are able to implement your program." Armed with this commitment the ladie set out with the strong help from SHO to open their clinic.

Opposition from the black doctors at 51st and State Streets was strong. These doctors saw the Taylor Clinic as another attempt by the University of Chicago and Michael Reese Hospital to continue white dominance of health care facilities on the South Side of Chicago. The presence of white students from the University of Chicago at all Taylor Residents' Health Committee meetings only confirmed their suspicion, despite earnest disclaimers by students. Besides this, the doctors were confronted with a new phenomenon—a group of black women who had familiarized themselves with new developments in Chicago like the Neighborhood Health Centers and who had organized themselves solely around the health issues. These ladies were demanding a measure of real control in the delivery of health care in their own area—a concept new to Chicago and to all its doctors.

The conflict came to a head on January 25, 1968, when the Taylor ladies, three SHO students, the doctors, and some city health professionals clashed in a stormy meeting. The doctors tried to explain the long history of discrimination against them which each physician knew well from bitter experience. They described the sorrowful but common phenomenon of a black man preferring a white doctor over a black doctor of equal or better training and ability because of the unremitting brainwashing that blacks had received. "During my residency," said one of the doctors, "a white resident and I walked onto a ward filled with black patients and they wanted him, not me, to care for them." The chairman of the meeting was one of the nine black doctors who had filed suit in 1961 against a number of defendants including 40 Chicago hospitals charging them with systematic exclusion of black doctors from their staffs. (An out-of-court settlement was reached by which the hospitals agreed to admit physicians to their staff without regard to race and the doctors reserved the right to reopen the suit if the hospitals did not comply.) The physicians at the meeting expressed the view that the proposed clinic would be another inad-

equate and unrealistic response to the community's needs. In the end not one of the approximately 25 doctors present spoke in favor of the clinic.

If the ladies and the SHO students didn't appreciate the positions of the battle-weary doctors, neither did "the doctors seem to appreciate the significance of this effort and how important it was to the ladies of the Robert Taylor Homes" (from a letter written the next day by a witness to the meeting). SHO, instead of relieving tensions, only widened the gap between the Taylor ladies and the doctors. The SHO students were unaware of the fact that many of these black doctors have been attempting to improve the health conditions of their people for many years.

As long ago as 1956 the building of a new community hospital on Chicago's South Side had the support of several of the black physicians. In 1965 they endorsed the concept of Neighborhood Health Centers and Provident Hospital submitted a letter of intent to cooperate in the establishment of such a center. (*1*) All of these efforts came to naught.

The students were surprised to learn that, due to discrimination in medical schools and staff appointments, there are only 7,000 black doctors in the United States. In Chicago, 50 percent are over the age of 50 and 25 percent are over 65. The number of black physicians practicing in Chicago today is no greater than it was 20 years ago; indeed, it is believed to be slightly smaller, while the black population has almost doubled in the same period of time.

The SHO people didn't understand the doctors nor did they understand the devastating implications behind whites "helping" blacks organize and the subtle damage that this "help" can do to black efforts to organize themselves into a position of strength.

Several young men from a black youth organization clued SHC in. Upset about the whites coming unannounced into their neighborhood, they walked into an early July 1968, meeting of the 12 Student Health Project people assigned to Taylor Homes for the 1968 summer and asked what they were doing in the neighborhood. The health science students explained as best they could.

One 19-year-old black youth told the whites to leave Taylor Homes. He said he represented 3,000 others like himself who resented the fact that SHO "sneaked into Taylor without telling anybody they were there." The rest of his arguments are worth quoting directly:

> This is a ghetto. We are trying to make it a community. The reason it is a ghetto is that the people here have no control. People like you can sneak in and out. In a community the people control their lives.

When asked about how the ghetto's problems would be solved, he answered,

> You're the problem. If you go, we'll solve the problem. You people are here to experiment on us. The only thing you can do is give us your money and leave.

The black youths objected to having any whites in positions of authority, which, obviously, they still held in the Taylor Clinic. These young men were justifiably angered over the atrocities perpetrated by the whites against blacks. They objected to anything that fostered dependency on the white man. They didn't want their women undressing in front of white doctors or a perpetuation of the situation of black school children who saw nothing but white teachers. To a white clergyman who was present they said, "Get out, we don't want no more Father Groppis." His answer, "I am staying," only angered them more.

Despite warnings that they would hear "Whitey, go home," the health science students were unprepared for this confrontation. Some began to leave immediately but most of them just sat bewildered. Who were these guys? Did they really represent 3,000 other youths? Were they even from the Taylor area? The questions were understandable, but regrettable. They didn't understand what the guys were saying, i.e., that the 300 years of brutal oppression of blacks by whites has to stop. So rather than concentrating on the content of the

blacks' message, the SHO people could only say, "Who are these guys?" Malcom X had reached the blacks but not the whites.

Realizing that the whites couldn't comprehend what was happening, the young blacks from Taylor resorted to threats of bodily harm which the whites did understand. The SHO members decided to leave the church because it was not safe to remain, but they vowed to continue to work on the clinic.

This decision to continue working on the clinic was very much in keeping with the historical approach of whites to black communities. At best, the students assumed that the small group of people that they had made contact with were the voice of the community; at worst, they assumed that this decision was theirs to make and not the community's.

In their naivete, the students could not immediately understand that giving health care could ultimately damage the community. The decision to stay was made from their own personal bias. It was facilitated by the opinion of the ladies of the committee, but the ladies represent only a segment of the community.

One student, who had had previous experience working in black communities, was already familiar with the problems engendered by her presence. Consequently, she was more concerned with pinpointing the ultimate causes behind the health care problems than with setting up a single clinic. To her the important question concerned the point at which they could most effectively apply pressure to ameliorate the entire situation. She "felt guilty for getting into a situation like this because she had been in a similar situation before," and said,"I should have known better."

The early confusion of the eight health science students and the six high school students assigned to the Taylor Homes area for the 1968 Summer Project added enormously to the problems. As a result of communication problems between the groups of 1967 and 1968, the students, including the area coordinator, did not clearly understand the background of the Taylor story. They did not know the members of the Taylor Residents' Health Committee or what the committee did. One said, "It seemed to me the residents weren't doing anything," indicating complete ignorance of what had happened in Taylor.

The drive and stamina of the Taylor Residents' Health Committee was, and still is, the central reason for the existence of the Taylor Clinic, even considering the great amount of work done by SHO. During the incredibly hard year-long struggles against Chicago's political machine, opposing doctors, and indifferent hospital officials, the SHO representative to the committee during the 1967–68 school year said, "I felt like quitting many times, but the ladies just would not quit."

During their 1968 Summer Project orientation the students got the impression that black students only, and not the whites, would have contact with the black community. The whites were to gather supplies, raise funds, and perform other tasks that had to be done if the clinic was to run. Above all, no whites would do any "organizing" in the black community. All this sounded fine but things didn't work this way. Whites did contact the community. They were present at all clinic meetings, and they definitely influenced policy decisions.

There were other sites in the Taylor area where the SHO people could have worked, but they seemed "so unstructured" that the health science students rejected them. At one site a medical student was expected "to cure a retarded child," which understandably scared her away. So, it was a case of too many SHO people knowing too little about the enslavement of the blacks which still continues today and about the resulting present-day black drive for freedom. By the end of the summer, 1968, when the vestiges of white student control were being eliminated one admittedly naive health science student could nevertheless say, "I don't think we should have been there in the first place."

By September 1968, things had changed. The clinic was operating two nights a week with the number of patient visits, then numbering about 15 per night, increasing each night as the clinic became more widely known.

Doctors and nurses, all but one of them black, were volunteering their time steadily. (Taylor black youth, in their efforts to make the clinic viable in their own community, would not allow any whites to work in the clinic and this included white doctors. Once the clinic had opened and functioned under these conditions, the youths, because they did not want to deny the community medical services, voted to allow up to five white persons to work in the clinic each night.) Procedures for culture taking and hospital referrals were still not smoothed out. But the Taylor ladies were carrying the burden of the work. Local black doctors who originally opposed the clinic were offering their time. (The young men from Taylor were escorting black nurses from the bus stop into the clinic and protecting the clinic.) The ladies themselves were obviously proud of their work.

What had happened? What brought the ladies, the young men, and the local black doctors together? The real answer is simple to state, but the meaning is profound: everybody working in the clinic was a member of the black community. The Taylor ladies, 10 local black doctors, representatives of three other community organiaztions, and two black nurses met on July 30, 1968, and for the first time they calmly discussed their mutual problems and the future of the clinic. It is most significant that *no whites were present.* Whites were not invited. The doctors, seeing that no outsiders were strongly influencing or controlling the clinic's policies, agreed for the first time to work for the Taylor Residents' Health Committee in the clinic. These community groups themselves went a long way toward repairing the splits among themselves. This was facilitated, to some extent, by the efforts of the black SHO students to contain any destructive white influence. "In my mind," said one of the black students, "the July 30th meeting was the beginning of the clinic and the end of the construct of some white man's mind." The earlier meetings between these groups were stormy partly because, with outsiders present, there was a constant undertow of feelings. Blacks differing with each other in front of a white man "was like hanging out their dirty laundry in front of whites," as one observer put it.

Unfortunately there are still residuals of white intervention which still cause bitterness. For example, the ladies when faced with getting some technical job done immediately have a tendency to turn to the long-standing dependency on white students rather than to black people who may, with admittedly more difficulty, be able to accomplish the same thing. This artificial dependency upon whites, which doesn't have to exist, weakens the black community. That dependency is exactly what the young blacks hate most. The black volunteers now working with the Taylor Committee to increase the power of the black community must now surmount an extra obstacle placed there unintentionally by white students. The dependency relationship fostered by white people working in the black community slows the cohesiveness of the black people working in the clinic. Until these splits between the various segments of the community are bridged, the black community will not be organized enough to resist the encroachment of a Model Cities program or neighborhood comprehensive care center that may not be in their best interest.

No one can judge now what will be the long term value of the Taylor Clinic in the black community. Mrs. Collins has always maintained that "politics is our real problem." Her committee waged an incredibly hard political battle with an insensitive, if not oppressive, city administration. But the fight is just beginning. Other battles are coming.

The lessons of the Taylor story are classic. First of all, there is the power of the black community embodied especially in the women of the Taylor Residents' Health Committee and in the Taylor youth. They created something that didn't exist before despite tremendous obstacles.

SHO made some big mistakes. It's tempting to say that knowing the black man's view of history could have kept the SHO people from making these errors, but that's too easy. How does a white get this knowledge or appreciate its meaning? One thing for sure—it's very

hard, but not impossible, for one man to understand another, especially if one is black and the other white. This takes a constant, monumental effort. Today the burden of that effort is on the white man because he has to change.

It would be presumptuous to lay down directives for SHO based on the Taylor story. But one question does deserve an answer: How is it possible for whites to come to a knowledge of the black man? Definitely not as the whites in the Taylor story did. Some of them learned things that will change their lives decisively, but the black community paid a high price for that knowledge. On one hand, the Taylor project appears to be functioning. On the other hand, the clinic is not yet funded and there are serious problems in persuading practitioners —black or white—to regularly give their time in a volunteer situation. In their process of learning, SHO attempted to treat a symptom rather than the cause. Since concerned black people made a concerted effort to prevent the clinic from becoming an issue that would further divide the community, the black community did not suffer from this "learning process" as much as it might have. But this student venture may be instrumental in adding another incident in a long series of disappointments, as well as acting as a channel to divert energy from places where it may more effectively be placed.

Students do not need to organize in poor communities—Appalachian white, Spanish or black—to learn about the problems that affect the poor. Middle class whites are foreigners to the poor and always will be. The real problem lies in the white community and must be dealt with there.

Woodlawn

Woodlawn is another almost all black community on Chicago's South Side. It is geographically adjacent to the University of Chicago with it's massive resources.

Woodlawn's boundaries are the Midway (6000 south) and 67th Street (6700 south) except for a small strip that goes to 71st Street (7100 south); and Lake Michigan on the east and South Parkway (400 east) on the west. (This latter street has just been renamed the Dr. Martin Luther King, Jr. Drive)

Woodlawn is community area 42 and the population reported in the 1960 census was 89.1 percent black. (*2*) Approximately 77,000 people were estimated to be living in Woodlawn in 1964, 93.4 percent of whom were black. (*1*) In 1960, 27.0 percent of the families in Woodlawn had incomes below $3,000 per year while the median family income was $4,797 per year. In that year 11.5 percent of the male labor force was unemployed and 30 percent of the housing was substandard. (*2*) No new housing has been built in Woodlawn since that time, although such housing is now being contemplated. If there have been any changes since 1960 in the parameters of this community, they have been for the worse, not the better.

Woodlawn is considered a zone 2 poverty area. It ranks in the first quartile (the highest rates) for all five morbidity-mortality factors. (*1*).

Two SHP teams were assigned to Woodlawn projects this summer. One of these was a sex education program conducted at a neighborhood center. (This same center also offered a variety of programs, including arts and crafts, physical education and tutorial work.)

One health science student and one high school intern participated in the sex education program. It offered girls, between the ages of 12 and 19, sex education including information about basic anatomy and physiology, the reproductive organs, personal hygiene, venereal disease control, birth control, and nutrition.

A number of community organizations (Woodlawn is a more highly organized community than many others), cooperated with the program. The team felt the program was successful and are hopeful that it will be the beginning of an ongoing educational tool for the community.

The medical student on the team wrote:

> I now feel that the time remaining in medical school should be focused on gaining the quality of medical train-

ing which will enable me to be a good doctor as well as a concerned and hopefully aware doctor in an inner-city ghetto clinic.

The team's "Final Report," is reproduced, and describes this experience.

Sex Education Program in Woodlawn.—by Dorothy R. Davies (Medicine), Georgia L. Houston (Intern)

The project has involved exploration and work at several levels:

1. Meeting with representatives of a number of community service agencies in the Woodlawn neighborhood to obtain their opinions of (*a*) the central needs in reproductive care education in the community; (*b*) most effective means of meeting those needs; and (*c*) what services their agencies might be able to contribute to an educational program.

2. Teaching sex education classes to three groups of teenage girls, exploring several different techniques and media, as well as more and less effective means of publicizing classes.

3. Surveying available films, books, and pamphlets pertinent to such a course.

4. Writing a permanent course outline for a 10-session sex education program based on the information and understanding gained from 1–3, as well as work done in the spring quarter to write a course outline for prenatal care classes.

5. Working with various resource agencies and individuals to establish an ongoing program which will be carried out primarily by community people, and available to whatever community groups are interested.

There has been an effort made to share as much as possible of the information and understandings gained with individuals who, while not directly involved in the program outlined in the attached grant proposal, are likely to be involved in sex education in the course of their responsibilities. Perhaps most gratifying along these lines was the dialog which took place when a street-worker from Youth Action, a representative of TWO, of the TWO--U. of C. experimental school project, and several others were brought together in a meeting to discuss possible ways of meeting the sex education needs.

A discussion of effectiveness of attempted means of publicizing classes; bibliography and revised pamphlet list; course outline; and a review of available films including an evaluation of their usefulness is available from the Chicago Student Health Organization.

Woodlawn Child Health Center

The University of Chicago, founded by the Children's Bureau, has established a comprehensive child care center in Woodlawn. Free medical care and social services are provided to Woodlawn children up to age 18 years.

Three high school interns and one health science student were assigned to this center. Their duties included acquainting the community with the danger of lead poisoning and assisting Woodlawn residents in finding screening and treatment sources for lead toxicity. They went door to door in the community with a pamphlet dealing with lead poisoning that was produced by last year's SHP team in Woodlawn. They also worked with a special committee on lead poisoning established by the alderman who represents Woodlawn in Chicago's City Council.

The following portion of a student's report describes this experience.

Guess one can learn about a bureaucracy only by dealing with it.—by David S. Sargent (Medicine)

My efforts eventually came to focus on the lead poisoning problem in Woodlawn. During the first few weeks of the summer I made numerous visits to the homes of lead poisoned children who had been seen at the clinic. One of these cases, a girl who was hospitalized at Wyler Children's Hospital with lead encephalopathy, dramatized to me how senseless and potentially tragic this disease can be; I had followed the purely medical aspects as well as the social aspects of this case.

Nearly all of the buildings I visited had bla-

tant violations of the city building code. To satisfy my own curiosity I decided to find out why the building code had not been enforced in these instances. My approach was to phone the building department and ask what violations they found in specific buildings and what was being done about them. This sounds easier than it actually was.

My first call lasted about 1 hour; 45 minutes of this time was how long it took them to put me in contact with the person who could give me the desired information. I talked with eight different people altogether, all of whom, except for the last one, sounded equally vague about how I could get this information. The eighth fellow I talked to said he would check their files for the status of the building I was asking about. Although subsequent calls to the Department required less time, since I then knew just who to talk to, still, I was amazed by how completely nonchalant and impersonal some of the people sounded. Guess one can learn about a bureaucracy only by dealing with it.

A few conclusions can be drawn from this "investigation" which required a large amount of time both on the phone and in the neighborhood. The building department seems to be a very slow, inefficient bureaucracy, completely apathetic about the living situation of the thousands of slum dwellers in Woodlawn.

Hang ups in the enforcement of the building code appear to fall into two groups. In one case, violations somehow slip by "unnoticed"; substandard buildings are given a clean bill of health. An example of this situation was pointed out by one very good newspaper article which came out during the summer. Why it occurs is unexplained; I was told by the building department that it is "being looked into."

In the other group, violations have been found in a building and the case is presently being "processed." Unfortunately, in numerous cases, this processing apparently lasts a number of years. The inspector's report of violations slowly makes its way to a secretary's typewriter, on to the Compliance Board, and eventually to the Corporation Counsel which submits the case for court action against the landlord. Who knows how long the court action lasts? The landlord may eventually have to pay a small fine, an amount considerably less than the cost of building repairs. He pays, but supposedly still has to fix up the building. After more inspections, more processing and more court action, the building might eventually be boarded up. While all this is going on, the paint continues to flake, the plaster continues to crumble, and young children continue to eat both the paint and plaster. Massive numbers of substandard buildings are presently inhabited by families with children, but the building department will not move.

There is a more practical side to my efforts on the lead poisoning problem. I have been working with a group called the Chicago Committee Against Lead Poisoning, which was started during the summer by Alderman Despres. Although its overall goal is to eradicate lead poisoning in the Chicago area, a more immediate goal is to amend the city housing code such that it will be more enforceable with respect to the elimination of peeling paint and broken plaster in Chicago housing. Petitions have been circulated by members of the group, and these will be sent to the mayor as a show of support of the amendment proposed by Alderman Despres. The amendment is to be introduced at the city council in September.

All in all, my work with the Chicago Student Health Project has been very enlightening for me and somewhat productive for the community I worked in. I consider these summer projects very valuable with respect to broadening the views of students in the health sciences. Service to the community is ideally an equally valuable goal; however, it presently appears to be more of an incidental thing.

Despite the fact that Woodlawn is so highly organized and that a well-known youth gang considers Woodlawn "their turf," there was no report by the students assigned here of difficulties in working in the community. When asked if there were negative effects of their work this summer they answered that there were none. They did not appear to become enmeshed in black-white confrontations and did

not decry the possibility of SHP students working in Woodlawn again in the future.

THE SOUTHWEST SIDE

A number of student health projects were involved with communities on the Southwest Side of Chicago. Most of this area is still predominantly white. However, there are all black communities scattered throughout this part of Chicago. Students assigned to projects in this part of the city worked in both black and white communities. A brief overview of the Southwest Side as seen by several students (David and Elizabeth George and Robert Geohegan) is presented as an introduction to this part of the report.

The Southwest Side has been characterized as suffering from the problem of mass paranoia and mass denial

The Southwest Side was roughly defined as the area from Lowe (632 West) west to the city limits between Archer and the city limits. The ethnic composition overall is predominantly Irish, Polish, and other European groups, especially Lithuanian, although in fewer numbers. There are small pockets of Appalachians and Mexicans. Its eastern edge borders on the black ghetto and it is undergoing racial transition. It is a low to middle income working class area. Men work in factories in construction trades or in lower level white collar jobs. Income is lowest in black, Mexican, and Appalachian areas. Generally speaking, income rises as one travels west.

The health needs of the people in this area should be viewed in the context of this environment in which they arise. The type and adequacy of health services should be analyzed in terms of the broader social, economic, and political forces at work on the Southwest Side. This is important in the areas of both physical and mental health.

Little public attention or awareness has been focused on the health needs of an area like the Southwest Side. The ghetto and hard-core poor areas have received a lot of attention (at least in the form of studies) but areas like this which are one notch better have not been examined. Even the community organizations in the area tend not to recognize health care as an issue.

Do the people on the Southwest Side pay a higher percentage of their income for care which is less adequate than that received in other sectors of the society? At the same time are working people subjected to more harmful physical conditions than the executives who can more easily afford good medical care? What percent of their income do working people pay and how adequate is their health care? What is the effect of working conditions to which they are subject? How are community health standards influenced in an area of transition? Why do housing and therefore health standards decline in such an area? How can decline be prevented without an appeal to racism? What are the particular health needs of different ethnic groups? How can greater awareness of these problems be created so that the people of the area can demand what they need?

The Southwest Side has been characterized as suffering from the problem of mass paranoia and mass denial. To what extent is this situation caused by social, economic, and political factors as compared to individual and psychological factors. How, for example, does racial fear and hostility contribute to the situation? How are these fears and hostilities built up? Are they simply a matter of individual attitudes? To what extent are they the product of institutional forces? For example what part do politicians, news editors, and realtors play in causing racism, through the exploitation of racial fear in order to gain votes, sell papers, or make profits on the sale of property? What influence does the ethnic factor have? For example, how did flight from communism, or loss of status and property upon coming to the United States, influence the mental health of immigrants? What special generational problems have arisen? How does community powerlessness via the political machine and other special interests influence the development of alienation and apathy? Lastly how does the factory or industrial situation undermine men-

tal health? How is a man influenced when he has a lack of major decisional power over the purposes and directions of his daily work, or when he is just a cog in the machine monotonously repeating the same tasks? What solutions are required to the problem of mental health on the Southwest Side? Will individual and group therapy provide a long range solution or is basic societal change necessary?

The communities are almost exclusively white, except for a housing project on Cicero at the edge of Garfield Ridge. The area is a working class neighborhood. The largest ethnic groups are Polish, Italian, Irish, and Bohemian, and many of the people are third generation. Few of the middle-aged people completed high school. The values of these people reflect their educational level; thus, a couple will consider a new car or a well-kept lawn more important than a college education for their children. Many parents suffered from authoritarian upbringing; hence they often fail to demonstrate love in the home. They have been succinctly described by one of the local clergymen as "relatively affluent dropouts."

These people feel alienated. They feel that most of the public money being spent for the welfare of the city's citizens goes to the blacks, the influx of whom they greatly fear. Community spirit is notably absent. This is reflected in the fact that the only centers of any kind currently in existence are church-sponsored affairs; and the few community organizations that do exist were established largely in response to the race problem. The fact that the people do relatively well materially, with relatively little education, tends to make them individualistic. It is also highly significant that the youth problem is recognized by everybody but the parents. This denial of personal problems is in general manifested by a failure to recognize the need for change.

In the foregoing the students have not presumed to set forth "answers" but rather to formulate basic questions that must be dealt with in finding approaches to the communities' health problems and needs. Within this context the following reports on individual sites comprise a description of the students' work on Chicago's Southwest Side.

Benton House

The student's report that follows includes a brief description about the neighborhood that this settlement house serves.

I have come to feel, as have many others, that I belong in only one place if I want to change the world, and that place is in trying to change my own community.—by John Vogel (Medicine)

Coming from 4 days of orientation in Palatine, I was all set to get into the work of my site. I had chosen to work in a Mexican-American area, less than a mile from Mayor Daley's home. Nominally, this site was included in the Southwest Side group, but in reality was separated from the Southwest Side both geographically and ethnically. This subsequently proved to be disadvantageous because we found it very difficult to relate to the rest of the Southwest Side group. The other 20–25 people in the group, although working at different sites, often were able to interact with each other because they all were working, basically, in the same community.

Susanna Roberts and I worked at the Neighborhood Resources Center (NRC) of Benton House, which is a settlement nearby in Bridgeport, a white ethnic area. The NRC is a storefront at 27th and Normal. Our preceptor was the unit director of the NRC, Dick Hall. He and four neighborhood workers made up the staff of the NRC.

Add to this the Latin Kings, a loosely knit gang of neighborhood teenagers, whose main activities consist of (*a*) hanging around the NRC in the daytime; and (*b*) nighttime recreational activities—drinking, window-breaking, glue sniffing, etc. A really good bunch of kids but with nothing to do. I sometimes wonder if we who do have something to do are any better off, pursuing a structured existence which we might not choose in a less rigid society.

To top it off, throw in about 30 (sometimes they appeared to be 30,000) kids between the

ages of 2 and 14. Some of them were in the NRC's day camp, others just hung around because they, too, had nothing to do. All these people thrown together added up to one BIG happy family.

The immediate community itself, is not one of abject poverty. Most of the people are poor, but most are employed (usually underemployed) and are eking out a fairly dignified existence. One of the biggest problems in the area is that, having no established community organization and no militant spokesman, it suffers in terms of municipal services. Trash cans on corners are rarely seen, there is always broken glass in the rarely cleaned streets, etc. The rest of Bridgeport, well organized and very vocal, receives almost all of the ward's services.

The adults in the community have been too preoccupied with the teenagers—the vandalism, the drinking, etc. Dick saw that this had to be eliminated, as a first step in building a more viable community. Somehow, the kids have to be turned in a more constructive direction, at the same time that issues are raised on which the adults can focus—the more fundamental issues, such as housing, education, and health. Therefore, Susanna and I could be used to help people to begin thinking about these issues by doing something in the field of health to bring it to their attention. At the same time, we all agreed that whatever we did, it should be something that the area people could participate in so that they could convince themselves that when they set out to do something, they could succeed. The next logical step after this would be the formation of some sort of community organization so that the neighbors could have a permanent base from which they could work whenever they set out to do anything, including demanding their rights with regard to city services and other city obligations.

After Susanna and I had been there for about a week, there was a meeting of the neighborhood's "policy recommending committee." This group had done various isolated things in the past, but was basically a nonfunctional entity. Dick sent out a notice to about 1000 people (mostly parents of kids in the day camp) and about eight or nine women showed up at the meeting. (The men rarely attend unless they are pulled in by their wives.) Several things were discussed, including what to do about a run-down building across the street from NRC, the teenagers, and our proposed health fair. The idea of a health fair was well received, and at the end of the meeting it appeared that the neighborhood women had decided to have a health fair, whereas they had really been presented with the idea and said, "OK." Although I was not cognizant of it at the time, I was, in effect, acting in a somewhat racist manner by going into someone else's community, messing it up with something that they had not proposed, and learning from it. In the long run, this health fair will probably have had little effect on the neighborhood, one way or another. But in a more conscious community (e.g., the black community) this type of "messing up" can and does have disastrous consequences.

In any case, Susanna and I then began acquiring the services necessary to hold the health fair. We received, in general, excellent service from the Board of Health. We were not able to obtain chest X-ray mobile units, but we did get them to send a diabetes detection unit for a fair on a Saturday, and the diabetes units generally do not work on Saturdays. Much of our success at the board of health was thanks to Dr. Jeremiah Stamler. My impression is that the Board of Health, partly because of their stormy experiences with SHP last summer, and partly becaust of their general desire to keep things quiet in poor neighborhoods, decided this summer to give SHP people what they wanted, as long as nothing interfered with ultimate city control of poor communities.

We also persuaded the Salvation Army to send one of its dentists to our health fair (teeth are a big problem in this area), and the Urban Progress Center at 19th and Halsted supplied a Board of Health physician with equipment for doing lead poisoning testing on children under six.

In the neighborhood, various people were busy making arrangements for the fair. Some

made posters, others ordered hot dogs and pop, etc. The local priest, Father Peter, gave us permission to hold the fair in the basement of St. Anthony's School. Several times we showed movies on first aid, diabetes, etc., which we obtained from the Chicago Public Library and the American Medical Association.

As the day of the fair approached, the teenagers got into the act. They helped in various activities, and on the day before the fair, did most of the work as we built the wooden frames which were to house the booths.

The fair itself was a huge success. Everyone from the Board of Health showed up with their mobile units. The Salvation Army dentist showed up. The hot dogs and pop showed up. The fair made a net profit from the games booths we had set up. And lots of people showed up and were screened for diabetes, tooth decay, and lead poisoning. There were hundreds of kids, who spent almost all of their time playing and eating.

Our aim of using the health fair as a catalyst to get the neighbors to take action on their own proved to be at least somewhat successful. About a week following the fair, another meeting of the Policy Recommending Committee was held. About 25 people showed up. The landlord of the run-down building across the street had been invited, but sent the building's manager instead. A heated discussion evolved, in which the people there formed a special committee to guard the building against vandals, i.e., the neighborhood teenagers. The group as a whole was becoming very enthusiastic about everything going on in their neighborhood. This is the latest information that I have on what is going on in the neighborhood.

Looking back I feel that although I enjoyed the summer thoroughly, and got a real kick out of working with the people in the neighborhood, there remains the unavoidable question: Did I do anything to change the basic health picture in that community, or to change the basic socioeconomic picture? The answer to the question is definitely *no*. And it has made me question the value of SHP as it has been constituted. What have we been doing other than messing up other people's communities and learning from them? I have come to feel, as have many others, that I belong in only one place if I want to change the world, and that place is in trying to change my own community, that is, my medical school. I must try to make my medical school change in ways which will move it toward becoming an institution which serves *all* of the people, not just a few.

Garfield Civic Association

This community organization serves an area between Halsted and Racine Avenues (800 west to 1200 west) and between 51st and 55th Streets (5100 south and 5500 south). The population is almost all white with a few black and Puerto Rican families. It however borders the black ghetto east of Halsted and south of 55th Street.

The area is part of community area 61. This is a nonpoverty area with a median family income reported in 1960 as being $6,500 per year. However, 10.4 percent of the families earned less than $3,000 per year, and 6.1 percent of the male labor force was unemployed in that year. Also, 18.3 percent of the housing was in substandard condition.

It is predominantly a white working class-low middle income area with some problems very similar to those of their black neighbors to the south and east.

There were seven health science students and five interns working on the development of a teenage youth center and the organization of a parent cooperative recreational and educational program for preschool children.

The need for a teenage center was clear," SHP students reported:

> In an area with many teenagers, there was no movie theater, no soda fountain, no teen social center of any kind. In the summer, neighborhood teens spent their time in Sherman Park, on Garfield Blvd., on Halsted, and on front stoops. In the winter, they played cards. Teenage drinking, drug abuse, venereal disease, and

unwed pregnancies are major problems. The high school dropout rate is high; college attendance is very low.

The students polled adult opinion on their projected teenage center.

> Most people I talked to considered the youth center a fine idea, but many saw problems * * * They thought we would have trouble controlling fights and drinking, that parents would be too lazy to help, that we wouldn't be able to finance it. But the problem raised by nearly everyone was whether the center would be for whites only. Many claimed blacks and Puerto Ricans would be sure to come and start fights.

The site report by student Polly Young relates how the dangers of an "exclusivist" center, and of "outside" control were averted, to bring the community, at the end of the 10-week SHP involvement, to the threshold of realizing its teen center.

Following is Miss Young's report:

> The center may never really get off the ground. Lack of community interest and support, shortage of funds, or fights between rival gangs could close it. There is a possibility that it comes to worse than just failing: it could become a white power group. Even now, it is dangerous for black people to walk in this community after dark. White teenage gangs frequently beat black and Puerto Rican youths. The community as a whole seems unified only in its desire to keep nonwhites from moving in. The kids and the community could decide to keep nonwhites out, by force if necessary. SHO would have no power over any such trends in the youth center.
>
> At best, the youth center could really have some positive effects on these teenagers. They are as locked into their social positions as those in the ghetto. It would take expert counseling starting with young teens to break the present pattern in which the brightest kids often drop out of school from lack of interest. Such projects as the newspaper and the library, if successful, could do much to augment the inferior education many of the kids receive in the public and parochial schools.
>
> The plans for dealing with the health and social problems of the neighborhood teenagers are also possible, if the center is a success. But such programs would require the sustained effort of the interested health science students. A 10-week summer project would almost certainly not be enough.

Of the parents' cooperative preschool center student Pam Zumwalt writes:

> We were constantly forced to rethink our roles and tactics, and to question whether we should be spending our time helping communities build needed and community-controlled institutions if these then became yet another tool to perpetuate white racism * * *All of us increased our own knowledge of the breakdown which occurs in the white community when threatened by racial change, of the moral and tactical questions which ust be faced in attempting organizational work in such an area.
>
> More than 50 small children had summer fun and creative experiences at the preschool center, and the handful of mothers interested in maintaining the program in the fall found out for themselves how the city of Chicago curtails the development of community controlled activities of poor and lower class people. While we didn't make any impressive and lasting changes, in these respects our project was successful.

South Lynne

The only other predominantly white community in which SHP students worked was the

South Lynne area. This community extends from Ashland (1600 west) to Wood Streets (1800) and from 59th Street (5900 South) to 67th Street (6700 South).

It is part of community area 67. While the population in the entire area was almost 12 percent Negro in 1960, the particular portion called South Lynne is about 99 percent white of Irish, Polish, and European descent. There are small groups of Appalachian white and-Mexican Americans. The eastern edge borders the black ghetto and is, itself, undergoing racial transition now. Median family income reported in 1960 for the entire area was $6,695 per year, with the South Lynne section reflecting this same median. The percent of families earning less than $3,000 per year for the entire area was 12.5 percent population. The percent of unemployed in the male labor force was 5.2 percent. The area is considered to be a non-poverty area and is composed predominantly of a low to middle income working class population.

There were three student teams working on separate projects. These projects included:

1. A study of the location and availability of medical services and the identification of unmet health care needs in the area.

2. Aid to the community council's title search and real estate survey in a 30-block area, for the purpose of tracing down "block-busting" real estate brokers.

3. Aid in the establishment of the South Lynn day camp—a summer project "to give the children of the area something more to do than wander around the street."

Medical Services and Health Care Survey.—The team of four health science students compiled a directory of health services available to residents. The students also conducted extensive interviews with residents and local physicians to learn their assessment of health care facilities and needs.

South Lynne Day Camp.—Without indicating the number of children who were involved, the students report this as a successful undertaking, within the narrow limits of the objective: a strictly inner community enterprise involving some parents as well as children, serving mental and physical health needs through recreational opportunities.

Title Search and Real Estate Survey.—The students report that results of their survey were given to the organization under whose direction they worked. A notable by-product of this team's activity is their paper on "the changing community," which follows. Here the students have explored their topic in depth, examining and explaining social, economic, psychological, and cultural facets of their subject.

Their paper leaves no aspect of the anatomy of South Lynne untouched, revealing it as the very prototype of the "sickest" areas of urban life in U.S. cities today—the communities in transition from segregated white to ghetto black.

Speculators, slumlords, and real estate agents have a heyday.—by Marilyn Stanek (Psychology), Peggy McQuade (Law), Karen Kaye (Social Work), Katie Sawallisch (Intern)

To describe a "changing community" as an area changing from all white to all black is incomplete and therefore inaccurate. Rather the definition should include consideration of the economic and psychological factors involved in the process of racial turnover.

We can make such an analysis of South Lynne, especially the area from Ashland to Wood between 59th and 67th Streets. The specter of inundation has haunted South Lynne for several years. About 2 years ago the community was transferred from the police district to the west (all white) to the Englewood police department. This not only seemed to mark South Lynne as the next area to undergo racial change; but also heralded the switch from people-oriented police protection to property-oriented law enforcement. (This is a common pattern, however, it is difficult to estimate to what extent it affects South Lynne.)

The real estate industry has also marked South Lynne for change. The "Down's Real Estate Report" cited South Lynne as becoming all black in 2 years. Real estate speculators

started buying property in the area in 1967. The activity among the real estate dealers might have been delayed a few more years if South Lynne did not have a reputation for being "soft," that is, they would not bomb a house blacks moved into.

Being a "soft" community is certainly a credit to the people of South Lynne. Unfortunately, this area, with the potential for becoming a stable, integrated community will probably be an extension of the ghetto within the decade. (It is true that South Lynne has its share of bigots; but effective ties and/or economic necessity override prejudice in many residents. "I'm staying until it turns 50 percent black" is often heard.)

One of the main forces pushing for complete racial turnover is the real estate industry. Since the early part of the 20th century the real estate industry has made conscious efforts to maintain two housing markets—one black and one white. Considering the law of supply and demand on which our economy is based the existence of two housing markets is exceedingly profitable. That is, if the realtors can manage to limit the housing available to the population or one segment of the population, they can demand higher prices from those people. The great influx of blacks from the 1920's through the 1960's has provided that population.

In turn, realtors prey on the prejudices and misconceptions of whites to obtain dwellings at a reduced price. This phenomenon is termed "panic peddling." It ranges from blatant appeals to racial prejudice (i.e. "colored are moving in down the block.") now outlawed by the fair housing ordinances, to more subtle forms (such as sending a black man to the people living next to a house that is up for sale). Realtors also try to make the neighborhood unpleasant to live in. They may rent to a mother with 12 children. No judge, in conscience, would evict them; yet, black or white, 12 unwatched children can be a nuisance. Coupled with harassment over the telephone and other tactics even the least prejudiced will consider moving.

But when whites in a changing neighborhood decide to sell, they find it difficult, if not impossible, to put their home on the open market. Banks do not usually give mortgages to those wishing to move to neighborhoods designated as "changing," "high risk" neighborhoods. The owner must sell on contract. For the private owner as opposed to the real estate speculator, this is a losing proposition. The buyer puts down a relatively small amount—not nearly enough for a down payment in the higher cost all white area the seller is probably moving to. Therefore, the latter must borrow, possibly in the form of a second mortgage. Thus his housing market becomes somewhat limited and he must contend with added interest.

Most homeowners find it easier to deal through a real estate broker. If they are among the first two or three to sell in a block about to be "busted" they usually get a fair price. But then comes the rush of selling, the housing market is glutted, and according to the law of supply and demand the prices drop. Speculators, slumlords and real estate agents have a heyday. They are free to sell to the black market at inflated prices. Contract selling is again the most common method, but somehow it is far more profitable for the realtor. Maybe this is due to the realtor's willingness to foreclose. For, unlike the mortgage in which the debtor owns a substantial interest in the property, the contract buyer pays the interest first. In other words, for possibly the first 10 years he is paying nothing but interest. If he is even 24 hours late his contract can be forclosed. It would be as if he had been paying rent for all those years. Thus the realtor has the down payment and all the contract payments for as long as 10 years plus the option to sell again on contract.

Economics plays a part in another facet of the deterioration of neighborhoods like South Lynne—the movement of small businesses out of the neighborhood and the subsequent decay of the shopping area. The reasons shopkeepers give for leaving the community are varied, but three factors stand out most. First, small businesses are closing all over the country because they cannot compete with large firms. Sec-

ondly, a small business depends on regular customers from the neighborhood. The shopkeeper deals with them on a personal basis. Many of these people are leaving; yet white shopkeepers find it difficult to form the same type of relationship with members of the black community. Lastly, the problem of getting insurance is often the last straw—the shopkeeper leaves. We can well understand his distress. The small business operates on a small and not too stable margin of profit; when an area is designated "high risk" the shopkeeper can afford neither the insurance nor the risk of broken windows.

The loss of these businesses not only gives the shopping area a shoddy, decaying visage; but also makes it difficult for the old people who remain. What was once a 5-minute walk is now a trip to Ford City, requiring two bus transfers—that could put both a physical and monetary strain on the aged. Also when a person shops out of the community, shopping becomes a task, not another occasion to talk to one's neighbors.

Yet these old people can be among the community organizer's greatest resources. They have lived in the community 30, 40, 50 years—their friends are here. Their mortgages are paid off and they can live off their pensions. They are not ready to start again. And many of them simply can not afford to move. Contract selling does not supply a homeowner with enough immediate cash for a down payment on a home in suburbia. Yet if they sold through a realtor they would not get their price and he would sell to blacks. This would constitute an act of treason to the people that remained. Also many of those in late middle age have moved from other neighborhoods that have gone all black. Some of these people are fearful to the point of paralysis. Others are willing to stand their ground. They are aware of the scare tactics of some real estate firms and sometimes can even name the worst offenders.

However, to stabilize a neighborhood young white families are needed. Take South Shore, for example: technically it is integrated; but in some sections all the whites are old. So within 10 years the chances of these areas being integrated are slim. The organizer must look to another source of support. Young mothers often prove invaluable in this context. In South Lynne this group is angry. They are angry that their kids come home with their clothes in shreds. They are angry they cannot send their children to the grocery store without fear that the child might be robbed. They are angry and fearful for their children when they hear of both white and black gangs—girls and boys. However, anger and fear do not presuppose action. Yet the potential is there and it cuts across the lines that separate renters and homeowners.

Still inaction plagues South Lynne. Father Lawlor's racist block clubs have promised stability. They promised to bring whites into the neighborhood, to stop urban renewal and the extension of the "L," to regain racial "balance" in the schools located in South Lynne. They have reneged on each of these promises; but still they are a source of hope for a desperate poeple * * *

* * * Lack of organization in the area has not only contributed to the feeling of alienation, but has also heightened suspicion of each other. A man who has lived down the block from you can be your friend or can be a potential seller—to blacks. In South Lynne he is the latter. Such lack of trust is a fertile bed for panic peddling. If you do not know the man on the corner, you don't know if the real estate dealer is telling the truth—has he really sold his home, are blacks moving in at night?

Suspicion also reduces the possibility of confronting group fears and problems. They cannot confront the real estate brokers and slumlords who fleece both white and blacks * * *

We hope that we have presented a clear explanation of the economic reasons for complete racial turnover in a neighborhood. We do not wish to discount blatant racism as a force in the community. There are John Birchers, white supremacists and Nazis in some neighborhoods. But most of the people subscribe to the tried and true racial misconceptions pervasive in America. The roots of these are emotional and economic. For the community organ-

izer to try to reverse 40 or 50 years of indoctrination is difficult if not impossible. The most he can do is play on whatever sane and just sentiments they do hold to mobilize around issues that are related to though not directly confronting the institution of racism. That task is left to the young.

Englewood

Englewood is located in community area 68. Its boundaries are 55th Street on the north (5500 south); 75th Street on the south (7500 south); a jogging boundary which runs between State and Stewart Streets on the east (0 to 500 west) and Racine Avenue on the west (1200 west). It was estimated to have a population of approximately 97,500 people in 1964. At that time, 83.6 percent of the population was nonwhite, a change from 69 percent of the population in the 1960 census.

The median family income in the community reported in 1960 was $5,579 with 8.4 percent of the male labor force unemployed in that year. Over 14 percent of the housing in the area was substandard at that time. (*2*) A part of this community is currently in the process of urban renewal.

In a ranking of poverty community areas for mortality, morbidity indicators Englewood was in the first quartile (highest rates) for infant and noninfant deaths from influenza and pneumonia; and in the first quartile also for newly diagnosed cases of tuberculosis. It was in the second quartile for deaths from cervical cancer and deaths due to unknown and ill-defined causes. (*1*)

While there are two private hospitals in the area, 35.5 percent of its residents needing inpatient admission went to Cook County Hospital, about 9 miles distant from the community. (*1*)

An overview of the community, its organizations, its problems, and the activity of the students prepared by the area coordinator, follows:

Englewood Area Report.—by Patricia Rice (Nursing)

The active organizations in the Englewood area include:

The Englewood Civic Organization—formerly the Action Center
- (*a*) Englewood Citizens Housing Committee
- (*b*) Englewood Health Committee

The Englewood Community Organization

The Eng[illegible]d Businessmen's Association

The Gree[illegible] Association

Youth Action

Urban Progress Center

Miscellaneous Block Clubs.

These organizations, their relationships to one another, their major concerns, and their involvement in health-related activities are described.

(*a*) The Englewood Community Organization, located in the Englewood Terrace Apartments at 64th and Lowe shares office space with the Businessmen's Association and represents business and professional interests. Both hospitals located in Englewood are represented in this "community organization."

(*b*) Englewood Businessmen's Association is a coalition of business interests located in the 63d and Halsted shopping district. Their major interest currently is the Englewood Central Renewal Project involving creation of a central mall with peripheral parking lots and rerouted traffic patterns for the 63d-Halsted shopping area. This project was responsible for the demolition of many homes, among them the homes owned by members of the * * *

(*c*) Green Street Association. Originally like a block club, the Green Street Association was developed to fight urban renewal plans calling for condemnation of homes along Green Street, from 63d Street south. This part of the urban renewal plan was necessary to make room for the traffic bypass and peripheral parking lots. Originally the Green Street people attempted to identify areas of mutual interest with the Businessmen's Association and E.C.O. "We wanted a better community and a nice shopping area, too!" Eventually they took their case to court and lost. Some of these people are

still paying out the balance of their contracts for homes they've lost.

(*d*) The Englewood Civic Organization—formerly the Action Committee. The group no longer has headquarters, but operates with a president and several active committees.

(1) Englewood Citizen's Housing Committee is collecting data on dispossessed families, especially those relocated by the Department of Urban Renewal, re: quality and cost of new location as compared to previous quarters, and whether suitable relocation is, in fact, accomplished for these people. There is an attempt to document individual cases.

Followup is undertaken on buildings previously reported to the building department to see if an inspector has visited and whether appropriate recommendations were ever made or followed. In terms of lead poisoning, Englewood is second highest in the city in the number of coroner-confirmed deaths from lead poisoning for the last 7 years. A list of suspect housing is obtained and followed up.

(2) Englewood Health Committee was established in the summer of 1967 with the purpose of taking positive action to improve the health of the residents of Englewood. It includes in its membership representatives of the Englewood Civic Organization, Englewood Community Organization, The Green Street Association, the Salvation Army, St. Bernard's Hospital, several of the clergy and professionals in the area, community members served by the clinic, and SHO. This committee has worked to open the Englewood Community Clinic, now operating two evenings weekly out of the Salvation Army facility at 62d Street.

(*e*) Englewood Youth Action is composed of a group of young men actively engaged in working with the youth groups in the area. Major concerns seem to be the young men and women of the community and the social organizations they build. Overt concern with health issues has thus far been limited to tentative development of a V.D. control and treatment program which is emerging in cooperation with a representative of some other agency. Less apparent, but perhaps more important to the health of the community, has been the emphasis upon positive self-evaluation and the development of cultural pride and self-help programs through youth action workers in other communities. Mimimal relationships have been established through the efforts of one of the young women at the Englewood Clinic. Some of the boys have done volunteer work (painting) at the clinic. Others have been treated there on clinic night. An attempt was made to encourage relationships with the Englewood Mental Health Clinic when community residents complained about the gangs at a mental health meeting.

(*f*) The Urban Progress Center is engaged in a variety of educational programs including a lead-poisoning screening program that provides transportation to and from the U.P.C for children to be tested. Home visits are made in an attempt to encourage screening and to followup the positive tests. Seldom is action ever taken against owners of buildings where housing violations are reported and where poisoned children are found.

(*g*) Relatively inactive block clubs exist throughout Englewood. There is hope, however, that they may reactivate in support of the Englewood Community Clinic through the encouragement of some community women on the Board of Directors of the Clinic.

The Englewood Health Committee is the one group currently involved in health planning. This planning revolves around the major health issue in the community, namely the provision of ongoing, comprehensive health care to the citizens of Englewood. (Last year's SHP report showed the paucity of health care facilities and the fragmented, crisis-oriented services available to the residents.) Questions currently are raised regarding the advisability of a "free clinic," open on a limited basis, in an area so poor in health care facilities. Does the provision of yet another fragmented service oblige the group beyond the limit of the care they are capable of providing? Suggested directions include:

(*a*) Liaison with Cook County Hospital to provide easier access to county facilities for Englewood residents; (*b*) liaison with community hospitals and private practitioners in

order to weave a more comprehensive network of services available locally; (*c*) purchase of a building that once housed a hospital (now moved to another community) for the purpose of expanding into a clinic-community hospital organization that will exist independently of other community services; (*d*) use of the health committee and the clinic as an organizing focus from which the Englewood citizens can pressure the city and county to implement the proposed Board of Health Community Clinic in Englewood, and *soon!*

While these larger, directional issues are being discussed, the community representatives also consider details of clinic operation and policy:

(*a*) The application of a "means test" of sorts in an attempt to weed out those patients who can afford ordinary sources of health care. This was overruled by the community representatives on the board who seemed to thoroughly dislike the introduction of the paperwork and the techniques of prying used by other institutions in their community. (This issue was raised by community professionals on the board who feel that more cooperation with community physicians will be obtained if they have some guarantee that patients will not be "spirited away" by the lure of a "free clinic." Sears Foundation's investigators asked clinic representatives what precautions had been taken to insure that those treated in the clinic would be truly poor people and not merely those unwilling to pay for private care.)

(*b*) The ladies are considering selling chicken dinners through their block clubs in order to raise money for the clinic.

The major health problem is the lack of available health facilities other than the crisis-oriented emergency rooms in the community. The lack of coordinated health care and comprehensive care facilities was really the basis for the activity at almost all sites in the area. The two hositals existing in the community seem to behave more like businesses than service institutions. Hospital participation in the land ownership, clearance, and development activities in Englewood indicates existence of a strong relationship between health rights and housing rights in this community. Unfortunately, specific information was not obtained about hospital land ownership practices, even though requested.

Attempts were made to place students at both hospitals in Englewood; we were successful only at one. Here students explored the relationship between the hospital and the community by working in the emergency room and interviewing patients during and after the visits to the emergency room. The hypothesis was that Englewood residents would tend to utilize the emergency room as a source of ongoing health care. This was shown to be true; but the extent to which followup care was provided or encouraged and the quality of care received depended largely upon the efforts or lack of effort on the part of those individuals on duty in the emergency room at the time of the patient's visit (described more fully in hospital site section).

Students at the Englewood Clinic worked to provide the goods and services necessary for the maintenance of a volunteer clinic on a one- to two-night-a-week basis. After several weeks the students visited families served by the clinic and encouraged participation on the Englewood Health Committee. Those residents becoming active voiced their feelings about the quality of care avaialbe through already existing community facilities, including the two hospitals. They seemed to use their own experiences as background for establishing policy for their clinic.

Students working for the Housing Committee brought information regarding the treatment area residents had received from the city, specifically D.U.R., and at the hands of the community power structure, namely the Businessmen's Association. Information about contract buying practices was compared with data gathered by students in Ashland-to-Western Avenue strip whose residents were currently being "blockbusted" by unnamed realtors. It was apparent that in terms of housing, both the white and black communities were victimized; in terms of health, the white community seemed to be better off.

Information gained at the Mental Health Clinic showed how attempts were being made to unite communities around a mental health facility. Unfortunately, clinic progrms are currently limited to curative-restorative efforts, whereas evidence of mass manipulation of the communities in question suggests a need for preventive programs stressing self-determination for the people of Englewood. It was interesting to note that when white people from the western section of Englewood declined invitations to use the Englewood Mental Health Center, the staff of the center were unable to formulate an "outreach" type of program. While imbued with appropriate values in terms of the need for positive interaction between the white and black segments of the community, that staff seems unable to recognize the fact that the different factions represented in the community are not truly one another's enemies. Their mutual enemies are, instead, the *agencies* that control the housing situation, the delivery of services to the community and the availability of health care facilities to the people of Englewood.

The work the students were involved in at the specific sites just described follows.

The Englewood Mental Health Center.—This center has four programs which include a day treatment program, a program for adolescents, an aftercare program and a school program for parents and tachers. It is a Chicago Board of Health facility whose jurisdiction is broader than the Englewood community area 68. It is supposed to provide services to the population west of Ashland Avenue as well as east, going up to Western Avenue (2400 west). That portion of the jurisdiction is an almost all white community located in community area 67, known as West Englewood.

This is a working class, lower middle income area, threatened by the expansion of the black ghetto to its east (See "The Changing Community"). As pointed out in the area coordinator's report, this part of the jurisdiction does not utilize the Englewood Mental Health Center but the center is interested in extending its services into this part of the community. Thus, the agency director requested the white student assigned to the Mental Health Center site to work in the West Englewood part of the jurisdiction.

He was assigned to develop and disseminate information about the center's programs. He interviewed a number of leaders in the community, including ministers and leaders active in the major community organizatons.

His interviews and discussions with these people focused around the following questions: (1) What are the problems facing your community; (2) can the Mental Health Center be of value to your community; (3) what does the community know about the center. The student felt he had made important contacts in the area which would be pursued by the staff at the center. He felt there might be long range positive results in the development of relationships with the white community in West Englewood that would enable it to take advantage of the center's facilities and programs.

He summed up his recommendations in the following report which was submitted to the staff of the center.

South Lynne—Reflections and Recommendations.—by Robert Geohegan (Medicine)

It would be easy for the staff of this Mental Health Center to dismiss the South Lynne community as a lost cause. South Lynne people are afraid to come into Englewood to visit the center. Also, it is very likely that the South Lynne area will change from a white neighborhood to a black neighborhood in the next several years.

The staff feels an outpost cannot be established in South Lynne. The center simply does not have the manpower at the present time to develop separate programs at an outpost in South Lynne.

Some of the staff also feel that setting up an outpost would be catering to a bigoted community.

I personally think South Lynne should not be written off as an unreachable community. To call the situation in South Lynne hopeless is to take a defeatist position. This kind of response

is the easy way out. But it also would represent the center's shirking of its responsibilities. This is especially true since the staff has made little effort to get to know the people and the mental health problems in South Lynne.

My first suggestion is that the staff should decide immediately whether the center has a commitment in South Lynne. If a commitment is to be made, I think it should be undertaken as soon as possible and wholeheartedly. The community is already changing and time is an important factor. In spite of the attitudes of some South Lynne people, the fact remains that some of them need help. The community deserves attention and understanding of the center.

The recommendations I make for this commitment are as follows.

1. The center should send a staff member into South Lynne during the week to do intake work (e.g., at a church). The people of the community will more readily go to an intake worker stationed in their own community than to one stationed at the center.

In performing intake work with South Lynne residents, the center can get a better idea of the primary mental health needs of the community.

Through personal contact, the staff member might also be able to more effectively convince residents to come into Englewood to the center. If necessary, the Intake worker could personally accompany an individual to the center.

This intake worker would also engage in any follow up activities with people who have dropped out of programs, etc.

2. The possibility of having a community organizer working in South Lynne was suggested. A community organizer could perform several valuable functions. He could establish further contacts in South Lynne and make arrangements for staff members to meet with individuals and organizations in the community. He also could play an important role in setting up workshops with groups in South Lynne such as the clergy.

3. I would recommend that every effort be made to get South Lynne teachers and parents involved in the school development program which can effectively reach the community in a relatively short time. Through this program, more individuals can be made aware of the center. The seminars and discussion groups might also encourage a dialogue between black and white people.

The Englewood Clinic.—This clinic was begun as a result of the efforts of three groups in the summer of 1967. These included the Student Health Organization, The Englewood Civic Organization and a local branch of the Salvation Army. The best description of this clinic and its participants is contained in the following document prepared by the Englewood Health Committee. This committee includes health science students who were, and are, participating in the Englewood Clinic.

The Area Involved.—The Englewood Clinic is located at the point at which the south Chicago communities of Englewood, Washington Park, and Greater Grand Crossing meet. All three are classified as poverty areas by the Chicago Committee on Urban Opportunity; all three are Negro ghettos with low levels of income and education, poor housing, large proportions of the population on public assistance, and high unemployment and juvenile delinquency rates; in all three, the quality of health care available to the population is low.

Statistical evidence of the poor state of health prevalent in these communities is provided in the Chicago Board of Health Medical Care Report published in Sptember 1966. Some of the pertinent data from this report is included on the table on the following page.

Other data in this report demonstrate that both Englewood and Washington Park are among the poorest of Chicago's poverty communities with respect to health care. Greater Grand Crossing, while faring better than these two communities by many criteria, still suffers greatly from inadequate medical care.

Available health facilities in this area of Chicago are remarkably scarce. There are few physicans in private practice in Englewood. Of

the two private hospitals in Englewood and one in Greater Grand Crossing, none provides an outpatient facility and none serves over 10 percent of its community's hospitalized patients.

Public facilities include three Infant Welfare Stations, one in Greater Grand Crossing and two in Englewood, which provide only routine prenatal and well baby care. An additional Infant Welfare Station in Englewood provides specialized care for some types of infant disorders on a referral basis. There is, in addition, a Mental Health Center in Englewood.

Comparative Health Statistics: Englewood. Washington Park, Greater Grand Crossing, Poverty and Nonpoverty Areas of Chicago (1965)

	Englewood	Washington Park	Greater Grand Crossing	Poverty [1]	Nonpoverty
Birth rate [2]	32.9	26.6	22.6	28.9	19.0
Mother under 20 [3]	19.7	23.3	18.6	20.0	10.1
Illegitimacy	27.7	28.6	23.2	25.0	5.1
Prematurity	14.4	14.3	15.0	12.8	6.1
Infant death rate: [4]					
Under 28 days	25.8	33.1	30.3	25.6	17.0
28 days to 1 year	15.3	12.7	9.7	12.9	5.1
Causes of infant death:					
Influenza and pneumonia	9.8	9.0	6.0	7.9	2.2
Gastroenteritis and colitis	2.0	---	---	1.3	---
Percent of cancer deaths from cervical cancer	2.7	4.0	8.1	4.4	1.8
Bronchopneumonia [2]	1.0	---	---	0.5	---
Syphilis	2.8	4.2	2.2	2.6	---
Gonorrhea	21.3	27.8	14.2	14.3	1.4
Tuberculosis	0.9	1.4	---	1.1	---

[1] Nonpoverty and poverty are combined totals for all the city's nonpoverty and poverty areas, respectively.

[2] Birth rate and infectious diseases are number per 1,000 population.

[3] Mother under 20, illegitimacy and prematurity are percent of live births.

[4] Infant death rate and causes of infant deaths per 1,000 live births.

For a great many residents of these three areas—perhaps a majority—the only available source of medical care is the emergency room or the outpatient clinic at Cook County Hospital. These facilities are overcrowded and may require up to 2 hours to reach by public transportation.

The Englewood Health Committee.—The Englewood Health Committee was established in the summer of 1967 with purpose of taking positive action to improve the health of the residents of Englewood. It includes in its membership representatives of the Englewood Civic Organization, the Englewood Community Organization, the Green Street Association, the Salvation Army, the Englewood Mental Health Center, the Student Health Organization, and several of the Englewood clergy as well as other residents of the area.

The Clinic Site.—The clinic is located in the Salvation Army Building, at 140 West 62d Street, where there is a furnished clinic facility which was not in use. Use of this facility is being donated by the Salvation Army to the community; it is emphasized, however, that it is a community clinic operated by the community.

The facility contains three furnished medical examining rooms, an office, a conference room, a waiting room, and two washrooms. The clinic possesses most of its needed laboratory equipment and there is additional space for a laboratory and storage of medical supplies. Additional rooms are available in the building for use as offices or examining rooms as needed.

Staff.—The clinic will employ a full time director who will be responsible for the coordination and direction of all clinic services and programs. The director will be selected by the board of directors of the clinic and will be directly responsible to them. A part time secretary will be employed to assist the director in keeping records, handling correspondence, and mailings.

Volunteer staff present at each clinic session will include one licensed physician, two regis-

tered nurses, two senior medical students to perform histories and physicals, two junior medical students for laboratory work, one social worker, and a receptionist. Additional volunteer personnel will include lawyers, pharmacists and nutritionists.

Services.—For clinic patients there is a charge of 50 cents per clinic visit. Services to be provided encompass the spectrum of basic outpatient care including routine examinations, treatment of general medical problems, immunizations, lead poisoning screening, and eventually general dental care. Diagnostic studies include routine blood counts, urinalysis, tuberculosis skin tests, and electrocardiograms. Samples for further laboratory evaluation are sent to the Board of Health and cooperating hospitals (lead poisoning screening, Pap smears, cultures, etc.). Referrals for hospitalization and more complex diagnostic workup are made to cooperating hospitals and to Cook County Hospital.

Hours.—The clinic has been open every Wednesday night from 6 to 9 p.m. since May 29, 1968. This schedule will be extended to other nights of the week as resources become available and the clinic program expands.

Administration.—The policymaking body for the Englewood Clinic is a Board of Directors established by the Englewood Health Committee. The board is composed of representatives of the health professionals involved in the clinic operation and members of the community (who constitute the majority of the board). Of the nine community representatives on the board, six of these positions will be occupied by consumers of the clinic services. Upon payment of the clinic fee, a patient's family is registered as a "stockholder" in the clinic. This entitles the family to attend regular meetings of the board and to elect representatives to serve as board members.

Objectives and Philosophy.—

1. To help fill, in a small way, the critical need for medical facilities in the Englewood--Washington Park–Greater Grand Crossing area. It is recognized that this facility will be able to serve only a relatively small number of patients; it is felt, however, that it will perform a needed service for those people in the area affected most severely by the present shortage of facilities: Those at the lowest levels of poverty.

2. To demonstrate that a neighborhood health facility can best be directed and its priorities established by the community people which the facility serves.

3. To furnish health science students and health professionals direct contact with the health problems of a ghetto community and promote in them an understanding and an awareness of these problems.

Referrals.—One of the accomplishments of the clinic may be to increase the involvement of the community's hospitals in the community's health. St. Bernard's Hospital and Englewood Hospital—the two hospitals in Englewood—have agreed to accommodate patients referred from the clinic for hospitalization under Title 19 or Medicare. Similar arrangements will be sought with other area hospitals. Presently, reluctance of these hospitals to treat patients requiring payment from Department of Public Aid, or from Title 19 funds, contributes greatly to their isolation from the community.

Patients who cannot be hospitalized at one of the community hospitals are, of necessity, referred to Cook County Hospital. Whenever possible, referrals for certain types of diagnosis or care are made to existing agencies such as the Board of Health Infant Welfare Stations (prenatal and well baby care), Veneral Disease Treatment Centers, Municipal Tuberculosis Sanitarium Clinics, and the Tuberculosis Institute X-ray detection facilities.

Patients To Be Served.—The clinic serves patients from the Englewood district and those sections of the Washington Park and Greater Grand Crossing communities which are near the clinic site. To as great an extent as possible, patients wll be seen on an appointment basis. Walk-ins will, of course, also be seen. Patients may be referred to the clinic from the churches, public schools, and from the Englewood Urban Progress Center when they are

discovered to require medical care at these institutions.

Future Funding.—The Englewood Clinic will, in the future, attempt to become self-supporting. There are at least two routes by which this may be accomplished:

1. Many of the patients seen at the clinic will be eligible for payment of their medical expenses through public aid, Title 19, or Medicare. Eventually, it may be possible to finance the clinic entirely through these sources. There are a great number of difficulties, however, in collecting money from the agencies involved including vast amounts of secretarial work, delays in payment by the agencies involved, and in many cases, payments inadequate to cover the expenses of the care involved. Thus, for at least the first year, the clinic will have to be supported by nongovernmental funds.

2. The city of Chicago has tentative plans to build a comprehensive outpatient facility on the south side of the city. When these plans reach fruition—probably in the next few years—the clinic may be able to become affiliated with this facility and derive its support from the city.

Summary.—The Englewood Health Committee is seeking to establish a low cost medical clinic in an area nearly devoid of medical facilities. In addition to providing medical services to some of the area's indigent population which would otherwise be hard pressed to obtain other than crisis-oriented health care, the clinic will provide for community control in order to demonstrate that the consumers of medical services may best direct their own health facility and determine their own health priorities; it will help to increase the involvement of existing community hospitals in the care of community residents; and it will help to introduce participating health science students to the medical problems of a poverty area.

The students working in the various Englewood sites generally felt that the projects were useful but, in their essays, highlighted again their fears of "imposing" themselves on the community, "inhibiting" community participation by their presence and concern that they had achieved no positive results for the community. Indeed, in many cases, they felt they had no right to be in the community at all. However, there was a cautious note of optimism in the reports by the Englewood students that perhaps, just perhaps, they had made some positive contribution this summer. A few quotations from their reports describe their reactions:

> I feel that my summer was well spent * * * I became aware of health problems in the ghetto plus I have learned techniques and means of reacting to these problems. The Englewood Clinic is the kind of project that is ideal for SHP students and does not necessarily "use" the black ghetto for the learning experience of whites. I predict a tough future for the clinic but if it does survive it will hasten the infusion of governmental money into the Englewood area to improve the health facilities available.
>
> My participation in the SHO summer project left me with mixed feelings about its merits. * * * Undoubtedly, the greatest benefits derived from my activities this summer were those which I received in terms of education and insight gained about health problems in this city, and the myraid factors affecting its [un] equal distribution. The knowledge that I gained from talking to community members * * *, from newly acquired friends, from relevant reading material, and from personal experiences has deeply affected my thinking and attitudes—both professionally and personally. * * *
>
> The worst aspect of the project was the fraud that I gave as a white person acting as a representative of a "community" clinic. * * * I was painfully aware of this fact in all my dealings with the community. * * * Despite the amount of personal warmth and interest that a white per-

son shows, he cannot help but initially represent an authoritarian figure and all its ensuing evils. * * *

I plan to work with the clinic during the school year and therefore avoid the problem of abandonment that is so often inherent in this type of project, but I still have not resolved the serious problem of fraud. * * * I can only rationalize that I am offering a service to the clinic that they can use until they can find a true community person to honestly represent their clinic.

A sense of the inadequacy of their accomplishment, an impatience with the role, as one student describes it, of "parachutist missionary," a sense of despair over the community's unmet health needs, is common to almost all of the team reports. Studied together, their reports both affirm and refute the students' conclusions.

Affirmed, through survey findings and experiences with bureaucratic, or lethargic, or outmoded "establishment" agencies and procedure, is the tragic disparity of health care needs and their fulfillment in every poverty community. Denied, by the evidence in these same reports, is the students' frequent conclusion that their effort "didn't change anything."

If we recognize that awareness is a precondition for change, then SHP's teams awakened the beginnings of change for hundreds of persons in whom their activity created an awareness:

1. Of their own health care problems, by having to discuss them with an interviewer in a health survey.

2. Of facilities to serve their health needs, the "tests" that could help determine their state of health, through health fair demonstrations, lead poisoning and parasite screening programs, TB and dental checks in preschool centers, etc.

3. Of the possibility of working with others to secure care for mental as well as physical health, in organizing the health fairs, setting up day camps, planning preschool, or teenage, or senior citizen centers.

Recording the impact of her experience at the American Indian Center, medical student Laura J. Simon writes in the report she has titled "Indian Summer":

> * * * I realized that there are really two kinds of prejudice. One kind denies that people are similar; the other denies that they are different * * *. We are perhaps all too prone to the fallacy that lies at the other extreme, the error of assuming that people are *not* different. * * *
>
> It is unreasonable to expect a Sauk Indian to see American history in the same light as I do living in northern Illinois where his nation once camped. The same government that exterminated his ancestors in the Blackhawk War gave refuge to mine * * *. Many times in the course of the summer I was reminded of the differences between the experience of Indians in the city and my own experience.

Substitute "enslaved" for the word "exterminated" (although they were often synonymous), and we have an insight into the differences between black and white in the United States that validate the need to vest control of the community project in the hands of black, or Indian, or American of Mexican or Puerto Rican descent, urged in so many of the students' reports. The SHP reports tell us, in effect, that groups with such different, and bitter, memories of official mishandling cannot be expected to trust "us"—the dominant white society—until we have demonstrated that we trust "them" to the point of accepting their ability and their right to make policies and execute them.

There is one commonly assumed difference among the poor, however, which we must note a number of the SHP reports repudiate. It is the assumption that the black community suffers more than its socioeconomically equivalent nonblack community from the phenomena of dislocated youth and hopeless, apathetic adults.

> Teenage drinking, drug abuse, venereal disease, and unwed pregnancies are major problems. The high school dropout rate is high; college attendance is very low.
>
> Many (adults) saw problems * * * They thought we would have trouble controlling fights and drinking, that parents would be too lazy to help, that we wouldn't be able to finance it.

The description easily fits the stereotype concept of all-black communities like Lawndale or Woodlawn. In fact, it is student Polly Young's account of the all-white Garfield Park area in which her team worked to establish a teenage center.

The SHP experience in the communities confirms, with the dimension of reality which personal eyewitness alone can add, what "cold" statistics have long indicated: That poverty has the same impact everywhere. It suggests that while the need for health care services may be greater in the black community because its deprivation and poverty embrace more people, the need is no less serious in the impoverished or economically "marginal" nonblack area.

It suggests, finally, that a publicly subsidized, universal health care system for the poor and "marginal" communities, predicated on community control that observes the spirit and letter of equal rights incumbent legally as well as morally upon such a system, can serve to conquer racism along with the other sicknesses that poverty nurtures.

Other Reports

There were several students working with agencies and groups not directly affiliated with a single community. These were sites whose work affects the lives of residents of the city of Chicago.

These included students working on special projects with the Board of Health and with regard to the welfare laws in the State of Illinois.

The Chronic Disease Detection Program.—Since 1967, the Division of Adult Health and Aging of the Chicago Board of Health, under the direction of Jeremiah Stamler, M.D., has conducted a number of disease detection programs. In two public housing projects, the Dearborn and Lathrop Homes, over 500 persons were screened in a 14-month program. A followup study on the persons who were referred to sources of health care because of abnormal results was undertaken by two medical students as part of the Student Health Project in cooperation with the Board of Health's Division of Adult Health and Aging.

The reports of the two students who worked in the project are presented first as an overview of their work, followed by a description of their findings.

This seems to suggest that medical practice in poor neighborhoods has been substantially abandoned by graduates of the medical schools of the United States.—by Jack E. Berger (Medicine)

My summer placement was at the Chicago Board of Health's Division of Adult Health and Aging. The project we (Charlie Bass and I) undertook was a research effort to evaluate the effectiveness of the Board of Health's chronic disease detection screening survey. This program involves multiphasic testing for indications of chronic disease processes. The object of the program is to elevate the level of public health by catching chronic diseases (which are now the large public health problems, rather than the infectious diseases) before they reach crisis proportions in a given individual. The program provides subsequent referral for those requiring further investigation to existing medical care structures.

Several types of testing facilities are operated under this program, such as the stationary and mobile diabetes testing units. Our attention in this project, however, was confined to the multiphasic screening done at the permanent testing locations in the Lathrop and Dearborn Homes housing projects. The testing done at these two locations takes 2 hours of the screenee's time, and includes the following tests: (1) Blood pressure (taken twice), (2)

weight, (3) hematocrit, (4) tonometry for glaucoma, (5) urine protein, (6) urine sugar, (7) ECG, (8) serum cholesterol, (9) glucose tolerance test, (10) Pap smear, (11) VDRL, and (12) chest X-ray (optional). In addition, a short medical history was given by the screenees. The history gathered data pertinent to chronic disease such as smoking habits and the presence of any signs and symptoms of cancer.

After the results of the tests are available, patients with abnormal tests are designated as "refer for care." Those with serious problems are sent a letter immediately, informing them of the findings and urging them to see their doctor. Subsequently, the medical social worker phones them to see that they have sought care. If the person has no source of care, she arranges one for them. The less urgent cases are followed up after a lag of several months to allow the screenee time to seek medical care.

Although the multiphasic testing program was initially confined to the residents of the above-mentioned housing projects, in the last 3 years this free testing service was made available to anyone who is over 35 years of age and cares to call the Board of Health for an appointment. The program is currently operating without public relations of any sort, finding that word of mouth advertising alone is sufficient to fill the program with screenees. Some 2,000 persons are currently screened per year.

Initially, there were fears by local physicians that the program would constitute a governmental invasion of the traditional prerogatives of the private medical practitioner. With the passage of time the tension has cooled, perhaps ameliorated by the physicians' realization that the program was actually providing more grist for the "fee for service" mill.

The objective of our research, then, was to determine whether the chronic disease screening program was actually resulting in the delivery of preventive medical care, on a continuing basis, to those who gave indications of chronic disease processes. In our research we attempted to answer these questions: (1) Did the screenees who were classified as needing further medical care actually contact a doctor or other source of care about the findings of the screening survey? (2) Did this contact result in the diagnosis of a hitherto unsuspected disease process? (3) What type of treatment was instituted? (4) Did the doctor's diagnosis confirm the findings of the screening survey? (5) Were the patients actually followed for any length of time? Were they actually receiving "continuing" care?

The answers to these questions were made all the more interesting by the fact that a similar followup study of the Chicago Heart Association's Adult Screening in Industry program was being done in DuPage County. In this program, only the tests pertaining to diabetes and heart disease were done, but nonetheless, a valuable comparison could be made between the practice of preventive medicine in DuPage County as compared with the city of Chicago. It might be pointed out that virtually all segments of the urban population were seen in the multiphasic screening program. Most of the people seen at the Dearborn site were blacks, whereas most of those seen at Lathrop were whites. Financially, the persons screened ranged from welfare to affluence, but with lower incomes prevailing.

After some initial delay in defining the project, the research began by examining the population selected for our study. The sample consisted of all persons screened by the Lathrop and Dearborn Homes sites during the months of November and December, 1967, and January of 1968. This population was chosen so as to be comparable to the population being studied by the Chicago Heart Association as a followup to its Adult Screening in Industry program. This program is similar to the multiphasic testing program with the exception that tests for indications of heart disease and diabetes are the only tests performed.

The folders containing the history and test results of each of the 506 screenees in our sample were first gone through case by case. We retained the following information on all those who were referred for care: Case number, name, address, code numbers of abnormal

tests, name and address of their source of medical care. Out of the 506 in the sample some 186, that is about 37 percent were referred for care. Of these, 5 indicated that they received care from both a private physician and a clinic; 31 claimed a clinic for a medical center; 20 gave no source of care; and the remainder (130) listing private physicians. The following plan was developed to determine the medical fate of these persons. Each referree would be sent a questionnaire through the mail with a self-return envelope. Each private physician would be sent a letter explaining our project and informing him that he would soon be called for an interview. A considerable amount of time went into finding and verifying the doctors' addresses and zip codes. Many doctors had to be dropped from the study as we could not find their names or addresses in the telephone directory. Others were also dropped for interviews because they practiced outside the city. For those screenees who listed clinics, all of the names of screenees for each clinic were compiled and sent to the respective clinics along with a letter requesting that we be allowed to see their charts. Subsequently we phoned the clinics for appointments to look over their records. I found that the medical record librarian was the best person to contact concerning this matter.

We had some 24 clinics with one or more screenees listing them as their source of care. The clinic personnel were almost always very cooperative. The real problem here was that instead of talking with the doctor who was familiar with the patient, we had only a chart at which to look. In one exceptional case (Mercy Hospital Clinic) this was no drawback. In other cases it was very difficult to glean information from the chart. Most of the charts were poorly organized and nonsequential, but most importantly they were handwritten and practically illegible. Much of the crucial information, such as treatments and medication given was abbreviated or coded. In our cover letter to the clinics we asked that a person familiar with the charts be available to go over them with us. This rarely was the case. Usually the charts were pulled and waiting, but I was directed to some vacant desk where I could look at them without benefit of help. The secretaries knew little more about the charts than I did and were no better at trying to decipher the writing. Only an interview with the treating doctor could give us the accurate information we needed.

This presents a real problem with following up persons visiting a clinic or medical center, in that the patients have been treated by a number of different doctors (all with equally poor handwriting), no one of whom would be familiar with all aspects of the treatment given a particular patient. The real solution here is to have well kept, neatly written or typed records.

Once we were identified as being from the Board of Health, very few clinics gave us trouble about releasing the information. Our policy was to bring the release signed by the patients on screening only when it was requested. While making a visit to one clinic, one of the doctors became quite suspicious when he saw me going through some records. He gave me the third degree until I showed him a sample of the release form and promised I would send the copies of the releases for the patients whose charts I had examined. The releases were mailed the next day. This particular doctor had more on his mind than the technicalties of maintaining confidential information. He was very interested in the attitudes of medical students. He proceeded to probe me with such questions as "How would you characterize yourself politically?" and "Are you a Catholic?" and "What is it with you guys with long hair?" I did my best to give straightforward honest answers to his questions. For the record my hair covers neither my ears nor my collar. It soon became apparent that the man was a rock-ribbed conservative who enjoyed having a little fun at the expense of a "pinko" student. After carefully disassociating myself and my views from the Board of Health, we had about 45 minutes worth of discussion and/or argument in which we could agree on approximately nothing. He would not believe that black people had any trouble getting to Cook County Hospital. He said, "The police take them there

for free all the time." He denied that black schools in Chicago were inferior to white schools. On a more fundamental level he said that, "The trouble with the damn niggers is that they are genetically inferior." I told him that he was misinformed and blatantly racist. He cited his 20 years of experience in working with the "niggers" as ample evidence to support his views. He would not listen to the idea that environmental forces had a profound effect on development of personalities. He felt that "genetics determine 95 percent of everything." The whole conversation is not worth reproducing here except to show the extent of ignorance and racism in some of the practitioners of medicine. This man was neither senile nor southern. He held a teaching position in one of Chicago's medical schools.

As far as the physician interviews were concerned there was good cooperation in all cases. Many of the doctors were a little wary or defensive. Some of this disappeared once they understood what we were doing and that we had the written permission of the patient to obtain the information we wanted. Some of the defensiveness on the part of the doctors was probably due to the nature of the questionnaire itself. There was simply no way to disguise the probing nature of the questions and consequently no way to avoid feelings of guilt or defensiveness on the part of the doctors.

At the time of the interview almost all of the doctors had the record to be reviewed before them on their desk. A good many of the records that I saw consisted of 3 x 5 or 5 x 7 cards written on both sides and stapled together in the corner. A few other doctors had their records on official looking forms. Only one or two maintained their records on full 8½ x 11 sheets. Most of the doctors referred to the records consistently throughout the interview, but in one notable exception the doctor answered all of my questions without ever looking at the record although it was right before him.

An initial impression that stuck with me very markedly was that a high percentage of the doctors I interviewed were foreign born. In the initial weeks of interviewing I worked mainly on the South and Near West Side—the black and the "poor white" neighborhoods. Here it seemed that at least one-half of the doctors were foreign born. As I began to work on the North Side I found that few, if any, were foreign born physicians. This seems to suggest that medical practice in poor neighborhoods has been substantially abandoned by graduates of the medical schools of the United States. This observation seems to be supported by the fact that my partner who worked mainly on the North Side saw few foreign born doctors, and the two medical students doing the interviews for the Chicago Heart Association in DuPage County saw almost none.

One of the most revealing experiences of the summer was hearing the experiences of the two medical students working on the previously mentioned survey. Just in listening to their problems I could tell that inner city medicine was in a different ball park. They were working on the level of finding out what methods were favored by physicians for lowering serum cholesterol. I had only two cases that I can recall in which a followup serum cholesterol was even done. They noted that almost all of their doctors had group practices with plush surroundings and further that many practitioners had their own laboratory facilities. I talked to doctors in modest to ramshackle offices, none of whom had laboratory facilities on the premises. In addition the students working in DuPage County were quick to point out that they saw very thick charts on their patients, most of which were neatly typed, the doctors having dictated them to a secretary. This brings up one of the critical issues that the summer's work touched upon, namely the difficulty of getting testing done on low income people. Many doctors were quick to point out when I asked if they had had some particular test done, that they wished they could have had it done but, (1) the patient didn't want to bother with it because he was currently asymptomatic, or (2) the patient had neither the time to make another appointment in a testing lab to have it done, nor the money to pay for it. Thus, if the practice of preventive

medicine requires testing, the real failure lies not with incompetent doctors, but rather with the entire socioeconomic framework that dictates that: (1) Poor people do not think on a "preventive" basis but rather on a "crisis" basis, (2) that they have no money to spend on testing that they see little value in, (3) that they frequently do not take the time to go to a separate facility to have testing done, and (4) that the doctor who practices among the poor either will not or can not make the financial investment in laboratories that would help to ameliorate this situation. One offshoot of this problem is reflected in the fact that several doctors mentioned that they would rather have a patient put on welfare so that at least he can have his testing done. Another consequence of the lack of laboratory testing among the poor is that the Board of Health screening tests take on the role of diagnostic tests on some occasions. On other occasions the diagnostic test ordered by the physician is a poorer test than the screening test. That is, a referral based on a glucose tolerance test, for example, is followed up with a urine sugar, or perhaps a fasting blood sugar only. It seems to me that the problems mentioned here are going to have to be dealt with in a massive and radical fashion before we can expect to see great improvement in the health of the poor. Certainly this will be true as far as preventive medicine is concerned.

In this case the Board of Health's effectiveness is dependent upon the total medical milieu in which it functions.—by Charlie Bass (Medicine)

My summer's placement at the Chicago Board of Health at first seemed like an excellent opportunity to study a structure to determine the powers that be. I was told by my preceptor that the project would take a great deal more time that I had, and that the power structure was a great deal more complicated than I could imagine. As it turned out, all I learned concerning the Board of Health's structure was what I was told about the rudimentary formalized structure and what I saw of its daily operation. This part of my "radical summer" turned out to be a bust.

I was left to find a project within the Division of Adult Health and Aging that would at least be of value to someone, or some project that seemed of value to my partner, Jack Berger, and myself. The two interns on our site were concerned with the service and the laboratory facilities that the Board of Health operates. They thus went their own way to do what they could at the sites where they were allowed to participate. We talked with them only infrequently for the rest of the summer.

The Board of Health is involved in a chronic disease screening program which works out of two stationary sites, one on the Near South Side and one Near Northwest. This screening seemed like a very important project as it is a first step toward effective preventive medicine. Though the screening is on a small scale, it is at least an attempt at a beginning. It was within this project that Jack and I decided to do our research.

If the effectiveness of one system ultimately depends upon the functioning of another independent system, that one system must check beyond itself to determine its validity for existence. In this case the Board of Health's effectiveness is dependent upon the total medical milieu in which it functions. As effective a detector as the screening may be, if for economic, social, or psychological reasons a person does not get care, the detection is a waste. Our project this summer went beyond the Board of Health into a part of the medical care system, the hospitals, clinics, and private M.D.'s in an attempt to determine the ultimate effectiveness of the screening program.

Without going into the details of the project, I am left at present with only general impressions gained from physicians I've talked to and the records I've examined. The most dominant impression I have is of the extreme guardedness of the M.D.'s and even their nurses. This attitude is very understandable from merely the point of view of an invasion of privacy by a young individual who doesn't look exactly clean-cut, but it is even more understandable when one discovers the type of care that is given. Most of the M.D.'s had a great many rationalizations to explain the type of patient

care given, most of them probably containing a great deal of validity; nonetheless, these M.D.'s did find it necessary to give excuses thus acknowledging their knowledge that the treatment was less than ideal.

About one-third of the cases I investigated seemed to show some effective degree of followup which ranged from retesting for the suspected disease with the finding of normal results, thus not confirming the Board of Health's findings, to treatment for the disease suggested by the screening procedure. The other two-thirds can be accounted for by patients having seen their doctors but not telling them about the screening results, patients having not seen their M.D.'s in the 6 or more months since the screening, and the whole range of rationalizations given by M.D.'s. These explanations ranged from "this person couldn't afford a new test," "I don't consider these results abnormal," "she is too unreliable to treat the way I would like," to "you know this type of people" and a whole range of pleasant conversation to avoid giving specific answers to questions.

Nothing really new can be gotten from this study that hasn't already been shown in much more conclusive, dramatic, and meaningful ways. It can be seen that any system to improve health which depends upon the present system for dispensing medical care is going to be very severely handicapped and possibly reduced to total medical-economic ineffectiveness. The two general and oversimplified solutions made obvious from this study are that the health care delivery system must be radically changed or a separate independent system must be set up.

Report on Followup on a Sample of Screening Program Examinees Referred for Medical Evaluation and Care: 6 Months and 2 to 3 Years After Screening.[1]—by Charles Bass and Jack Berger

This study was designed to followup on persons referred for care because of abnormal results in the Chronic Disease Detection Program of the Chicago Board of Health. It was conducted by two medical students as part of the Student Health Project with the cooperation of the Chicago Board of Health, especially the Division of Adult Health and Aging. It was an attempt to answer three basic questions:

1. What percentage of the persons referred[2] actually contacted a physician?

2. Is the examinee under care for the abnormal condition(s)?

3. What is the response of physicians and examinees to followup efforts?

Two parts to this survey, one concerning persons screened 6 months prior to followup and the other, persons 2 to 3 years before followup, allowed us to compare the answers for two time periods.

The major population under consideration was that tested in the time period between November 1, 1967, and January 31, 1968, at the Dearborn and Lathrop Homes sites. A total of 508 people were screened during this period with 186 referred for care. For this group of 186, data were gotten from both examinees and medical care sources. The examinees were all mailed questionnaires with a letter of explanation and a stamped return envelope enclosed. The sources of medical care were sent an introductory letter which was followed by a phone contact asking either for an interview with the physician or a chance to examine the medical records. All sources of care who could not be personally contacted (primarily physicians with unusual schedules or those on vacation) were mailed a questionnaire with a letter of explanation and a stamped return envelope.

In the second part of the survey, 460 examinees (of whom 152 were referred for care) were chosen at random from older files ranging in time of being screened from December 10, 1965, to November 10, 1966. For this population, both examinees and medical care

[1] Under the direction and with assistance of Willie Cain, R.N., R. Raphaelson, Rose Stamler, M.A., and Jeremiah Stamler, M.D., for the Chicago Health Research Foundation and the Division of Adult Health and Aging, Chicago Board of Health.

[2] The criteria for referral for the major abnormalities discussed were: (1) Diastolic blood pressure of 95 mm. Hg. or greater (2) An abnormal modified glucose tolerance test, and (3) A specific abnormality on the ECG.

sources were sent questionnaires with explanatory letters and stamped return envelopes. Copies of all forms are available.

The tables below summarize the findings.[3]

Followup of Recent Examinees—Reporting for Care.—Approximately 59 percent of those referred for care reported that they had seen a physician after the screening tests (table 1). (An additional small precentage—2.2—answered this question negatively. It is assumed as likely that a large share of the 39.2 percent *not* answering the questionnaire did *not* report to a physician after the tests.) The three most frequent bases for referral—elevated blood pressure, elevated plasma glucose (after oral load), specific ECG abnormality—all seemed about equally compelling to examinees as reasons for reporting to physicians. About 60 percent of persons with these findings reported seeing a physician. Of those with other abnor-

[3] Where information was not obtained by the survey techniques but was available from the social worker's report it was included as indicated in the tables.

TABLE 1.—*Followup on a sample of 186 examinees referred for abnormal test results: Was physician seen?*

Description of examinee	Didn't answer questionnaire	Didn't see M.D.	Reported seeing M.D.		
			Total	Reported [1] via questionnaire	Social worker report only
Test findings:					
All	73	4	109	89	20
(N [2] = 186)	(39.2)	(2.2)	(58.6)	(47.8)	(10.8)
Diastolic blood pressure 95 mm. Hg. or>	10	1	15	12	3
(N = 26)	(38.5)	(3.8)	(57.7)	(46.2)	(11.5)
Elevated plasma glucose	20	2	39	34	5
(N = 61)	(32.8)	(3.3)	(63.9)	(55.7)	(8.2)
Specific ECG abnormality	32	2	54	43	11
(N = 88)	(36.4)	(2.3)	(61.4)	(48.9)	(12.5)
Other referrable abnormalities	22	....	18	14	4
(N = 40)	(55.0)	....	(45.0)	(35.0)	(10.0)
Sex:					
Male	18	3	35	29	6
(N = 56)	(32.1)	(5.4)	(62.5)	(51.8)	(10.7)
Female	55	1	74	60	14
(N = 130)	(42.3)	(0.8)	(56.9)	(46.2)	(10.8)
Race:					
White	42	2	67	59	8
(N = 111)	(37.8)	(1.8)	(60.4)	(53.2)	(7.2)
Nonwhite	31	2	42	30	12
(N = 75)	(41.3)	(2.7)	(56.0)	(40.0)	(16.0)
Age:					
30 to 39	24	1	24	20	4
(N = 49)	(49.0)	(2.0)	(49.0)	(40.8)	(8.2)
40 to 49	20	2	30	22	8
(N = 52)	(38.5)	(3.8)	(57.7)	(42.3)	(15.4)
50 to 59	20	1	30	25	5
(N = 51)	(39.2)	(2.0)	(58.8)	(49.0)	(9.8)
60 to 64	9	....	25	22	3
(N = 34)	(26.5)	....	(73.5)	(64.7)	(8.8)

NOTE.—Numbers in parentheses are percentages.

[1] Examinee questionnaire.

[2] Some examinees are in more than 1 test finding group.

malities 45 percent indicated they had seen a source of medical care.[4]

Males in this sample reported seeing a physician in a slightly higher proportion of cases than did female examinees (62.5 percent versus 56.9 percent, respectively).

The proportions of whites and nonwhites reported as seeing a physician were only slightly different (60.4 percent and 56 percent, respectively). As would be expected, considerably more older examinees reported they sought care when compared to those in the younger age groups (73.5 percent for 60 to 64 year olds versus 49 percent for those 30 to 39). It may be that the older examinees had more symptoms as a result of the abnormalities, or it may be that their older age has made them more frequent and regular visitors to the physician.

Is examinee following the recommendations of the physician?

The majority (56 percent) of those reporting that they had seen the physician also report they are following all or part of his recommendations (table 2). These 61 persons constitute approximately one-third (32.8 percent) of all those referred. (The actual percentage following M.D. recommendations is probably higher than this one-third. However, there is no way to know what percentage of nonrespondents actually received followup care).

In about one-quarter of the reporting cases (26.6 percent), examinees stated that the physician made no recommendations for treatment. No explanation is given in 17.4 percent of the cases, but in 9.2 percent, the absence of recommendations is based on the physician's decision that the examinee was normal. (In 5 of those 10 cases, the repeat test given was as stringent as the initial screening test. In 5 others, the test was less sensitive—e.g., urine test for diabetes versus initial modified GTT—or no test was made).

Physician Report. Information from the source of medical care was received for 104 examinees (55.9 percent of those referred for care) (table 3). Actually, the percentage of physicians cooperating in followup was slightly higher (63.4 percent), since requests for such information went to physicians in 164 of the 186 cases. In the remaining 22 cases, it was not possible to locate the doctor indicated as being the source of care.

TABLE 2.—*Followup on a sample of 186 examinees referred for abnormal test results: Are examnees who saw physician following his recommendations?*

	Following all or part of M.D. recommendations	M.D. found examinee normal	M.D. made no recommendations	Not following or doubtful if following M.D. recommendations	Didn't answer questionnaire and/or didn't see M.D.
Number	61	10	19	19	77
Percent of all examinees who saw M.D.	56.0	9.2	17.4	17.4	---
Percent of all referred examinees (N=186)	32.8	5.4	10.2	10.2	41.4

Most data in this table are from examinee questionnaires. In a few cases, information is from social worker followup.

Of the 104 persons for whom information was obtained from a source of medical care, 79 were reported as having been seen (table 3). They represented 76 percent of those for whom there is an M.D. report, and 42.5 percent of all those referred for care. The doctors report that 68 of the examinees were under long term care and that 40 of these were receiving treatment as a result of the screening referral; i.e., 38.5 percent of those for whom there was an M.D. report, and 21.5 percent of all those referred. One word of caution is needed in interpreting the report that 68 of the examinees (65.4 percent of those reported on, and 36.6 percent of all referred) are "under long term care." Apparently, physicians in responding to this question stated that persons were under their long term care even though they were not treating them for any of the abnormalities found in the screening tests. The more realistic estimate of the number under care is the 40 re-

[4] Such abnormalities include suspicious findings on cervical examination, suspect glaucoma, low hematocrit.

ported specifically as receiving treatment as a result of the screening referral.

Long Term Followup.—Table 4 indicates that there is probably a long range salutary effect of such a screening program, since 24.6 percent of those for whom there is an M.D. report are described as under treatment for the screening abnormalities. It also indicates, however, that the attrition in response rate to followup requests is great, and this interferes with any accurate assessment. Only 31.6 percent of examinees and 53.3 percent of M.D.'s responded to the questionnaires (as contrasted with 60.8 percent and 63.4 percent, respectively, for the followup of more recently referred cases).

Despite the lapse of 2 to 3 years, 58.3 percent of examinee responders reported themselves to be under treatment for the screened abnormality (table 4). This compares favorably with the 54.8 percent of the more recently referred examinees who also reported themselves as under treatment.

Summary and Conclusion.—A sizable percentage of examinees recently referred for followup medical evaluation and care (59 percent) report themselves as having sought such care. One-third (33 percent) of all examinees referred report that they were under treatment and following all or at least part of the doctor's advice 6 months after referral. (This percentage is higher—55 percent—if one uses the number responding to the questionnaire as the base, rather than all those referred.) Phy-

TABLE [illegible].—*Followup on a sample of 186 examinees referred for abnormal test results: Are examinees receiving treatment as a result of screening referral?*[1]

	Number	Percent of all examinees with M.D. report	Percent of all examinees referred
M.D. report received	104	100.0	55.9
M.D. saw examinee	79	76.0	42.5
Examinee under M.D.'s long-term care	68	65.4	36.6
Examinee receiving treatment as result of screening referral	[2]40	38.5	21.5

[1] Information is from M.D. response.

[2] 18 of these examinees reported that the abnormalities for which they were referred were previously known although not under control. 22 indicated that these abnormalities were previously unknown.

TABLE 4.—*Comparison of followup results in 2 groups of examinees: 1st group, 6 months after referral; 2d group, 2 – 3 years after referral*

	6 months after referral		2 to 3 years after referral	
Persons examined in sample	508		460.	
Referred for test abnormalities	186:	36.6 percent of examinees	152:	33.0 perment of examinees.
Examinee questionnaires sent	186:	100 percent of referred	147:	96.7 percent of referred.
Examinee questionnaires completed and returned.	113:	60.8 percent of referred	48:	31.6 percent of referred.
Examinee reports himself to be under treatment following referral.	61:	54.8 percent of responders 32.8 percent of referred	28:	58.3 percent of responders. 18.4 percent of referred.
Physicians receiving follow-up request	164:	88.2 percent of referred	107:	70.4 percent of referred.
Physicians responding	104:	63.4 percent of M.D.'s queried 55.9 percent of referred	57:	53.3 percent of M.D.'s queried. 37.5 percent of referred.
Physician reports examinee under treatment	40:	38.5 percent of examinees with M.D. reports. 21.5 percent of referred	14:	24.6 percent of examinees with M.D. reports. 9.2 percent of referred.

sicians independently report that 39 percent of those they saw after referral were under treatment. This constitutes 22 percent of all referred examinees. The discrepancies between examinee and physician report can be accounted for partly by the fact that some examinees reported to a physician other than the one listed at screening time, and this listed physician (the one contacted for followup) counted this examinee as "not reporting." Even after 2 to 3 years, a sizable portion of examinees report themselves as still under treatment (58 percent of those responding, although only 18 percent of the referred, since the response rate is low after such a time lapse.) One-quarter of those with M.D. reports are stated to be still under care (again, with a low response rate over time, this accounts for only 9 percent of those originally referred.)

The conclusion is that at least a third of those recently examined (and possibly up to 55 percent) do end up under medical care they might not otherwise have sought, for the treatment and control of major chronic diseases. Improved methods of followup (including built-in plans for intermittent or periodic followup) would increase ability to assess whether the salutary effect lasts over the years.

It is clear that this type of study did not and could not assess in depth the type of care and treatment received following referral. It is important to register, however, that the screening program is a valuable first step in bringing under early control those chronic diseases prevalent in a significant proportion of the middle-aged and older population.

Proposed Amendments to the Illinois Public Aid Code Relating to the Illinois Medical Assistance Program.—Lawrence S. Bloom (Law), Ralph McMurray (Law), Margaret Stapleton (Law)

I. Introduction

This report suggesting specific amendments to the Illinois Public Aid Code represents the implementation of research begun during the 1967 Chicago Student Health Project and published in the June 1968, issue of Inquiry magazine under the title of "Medicaid in Cook County." These legislative amendments are designed to revise the Illinois Medical Assistance Program in such a manner that it may more adequately serve the needs of those Illinois residents who are unable to meet their medical expenses.

It should be understood from the outset that the authors are not altogether certain the current welfare system is the proper framework for an adequate and effective health care plan. Patching up the existing system may do little good. In fact, it may help further entrench what should really be discarded. But with the prospects for a total rethinking of the problem very dim indeed, it is perhaps prudent now to consider those changes in the current program which will be most beneficial.

II. Defects in the Current Program

The basic framework of the current Illinois Medical Assistance Program is quite simple. Two classes of people qualify for free medical assistance: cash grant recipients of public aid, and those persons whose incomes are sufficient (by Public Aid standards) to meet daily needs but insufficient to meet medical needs. Coverage by the program is evidenced by a card which signifies to medical vendors that reimbursement for various medical services administered to the holder will be paid by the State of Illinois.

Through this system it could be possible to provide necessary health care in a dignified manner to those unable to pay. Unfortunately this is not the case. Specifically, the program:

(1) Fails to set reasonable standards and categories of eligibility thereby excluding from coverage broad ranges of deserving persons;

(2) Fails to include major areas of preventive care within the services for which vendors may be reimbursed thereby depriving program eligibles of an essential element of good health care and, in the large run, adding to the taxpayers' supporting burden;

(3) Fails to provide convenient efficient methods for procuring coverage under the program, thereby denying a large segment of our state's population quick access to the medical treatment afforded them by law, as well as depriving them of any measure of medical security;

(4) Fails to provide financial incentives and administrative efficiencies to medical vendors thereby alienating the medical vendors and discouraging their practice in poverty areas.

In a broader scope, the program:

(1) Reinforces the degrading image of charity medicine, and

(2) Takes little advantage of its opportunity to integrate publicly supported patients into the health care delivery system of the community as a whole.

III. Proposed Medical Assistance Program

The proposed statutory amendments would revise the medical assistance program to take the following basic form.

A. Eligibility

(1) All persons and families falling below the HEW "poverty line" for their particular family classification would be eligible for basic maintenance cash grants and hence free medical assistance.

(2) All individuals and families (hereafter refered to as "families") whose incomes do not exceed 133 percent of the maximum basic maintenance cash grant allowable to families of similar constitution would be eligible for free medical assistance.

Example: If a family of four with no income whatsoever would be eligible for a cash grant of $3,600 covering basic needs, a similar family of four which fails to qualify for a cash grant on the basis of need would still be eligible for free medical care if its income does not exceed $4,800.

(3) Assets (such as a car, savings, life insurance) would not be included in the computation of income. Families eligible on the basis of income under the standards set out in I(B), above, would retain their eligibility status so long as their liquid assets (savings, stocks, insurance, etc.) do not exceed 50 percent of the maximum income allowable for their family classification. Necessary assets such as a home, one car and a limited amount of life, health, accident and property insurance would be totally exempt from the computation of assets.

Example: Using the family of four hypothesized earlier, that family would be excluded from eligibility for medical assistance only if their nonexempt assets in the form of stocks, savings, etc., exceeded $2,400, i.e., 50 percent of $4,800, the maximum income allowed for a family of four.

(4) Applicants who do not qualify on the basis of need would nonetheless have the assurance that when their calculated excess income is exhausted for medical expenses, the State of Illinois would be committed to grant coverage for subsequent medical expenses. This would be accomplished by the Department's keeping an accurate record of all "rejected" applications, with a notation of the calculated excess income or assets available for medical needs. The applicant would then submit receipts of medical expenditures to the Department and if, within a prescribed period, these exceed his excess income, a medical assistance card would automatically be issued and full eligibility granted for the duration of the time his initial application would have covered had it been granted. The Department of Public Aid would be encouraged to devise a plan whereby those found ineligible for medical assistance on the basis of need could be given State financial aid in meeting

a percentage of their medical costs, without first having to totally deplete their excess income.

Example: If the family of four suggested above were found to have an income of $5,000 and assets of $2,400, eligibility for medical assistance would initially be denied. However, if this family were to incur medical expenses in excess of $200 during the 6-month period for which eligibility is now granted, it would then be eligible for coverage for the duration of the 6-month period. Of course, eligibility would be regranted if the family's financial status remained the same at the end of the 6-month period.

Comment: The purpose of these changes is two-fold. First, they increase the number of people eligible for medical assistance and grant some measure of medical security to those just beyond the eligibility limits. Second, with an enlarged group of potentially "fully paid" patients whose eligibility can be quickly ascertained, more and better physicians and institutions might be encouraged to serve poverty communities.

B. Medical Services Covered

Those services for which medical vendors could be reimbursed would be expanded to include preventive dentistry, physical check-ups and psychological counselling.

Comment: Aside from the necessity of these items to provide comprehensive medical care, effective preventive attention may in the long run reduce the costs of the Medical Assistance Program through a reduction in costly remedial services.

C. Administration of the Medical Assistance Program

(1) While determination of eligibility for medical assistance would remain the function of the Department of Public Aid, the administration of vendor billing and reimbursement would become the responsibility of a separate agency solely concerned with this task.

(2) For each individual or family found eligible for medical assistance, the Department of Public Aid would each month deposit with this payment agency an amount computed to be the average expected monthly cost of providing medical services to each person covered. Such funds would be irrevocably commited to the payment of Medical Assistance bills.

(3) Persons eligible for medical assistance would be allowed to have such monthly payments transferred to private medical insurance of group care plans to cover the cost of premiums required by such plans. From that point on, the medical relationship would be safely between the patient and his chosen medical care dispenser.

(4) Vendors who continue to submit vouchers to the State reimbursement agency would be entitled to interest on vouchers unpaid after a month's period of time.

(5) The State reimbursement agency would be authorized to make advance payments to medical institutions which on the basis of past billing can reasonably be expected to submit substantial payment claims. Specifically, institutions which in the past have submitted vouchers over a year period in excess of $300,000 could receive in advance 50 percent of an average estimated monthly reimbursement.

Comment: These changes would take the job of vendor reimbursement out of the Department of Public Aid and make it the responsibility of a professional payment institution. This, along with the interest and advance payment provisions, could help restore vendor cooperation with the Medical Assistance Program. Allowing persons covered by the Medical Assistance Program to transfer the funds set aside for their medical

needs to private institutions has several advantages. It allows greater control over the management of an individual's own medical care. It enables him to become part of the health care delivery system of the general community. It gives an added push to the development of group care plans in Illinois. And, incidentally, this provision may enlist the support of the powerful insurance lobby in support of the entire legislative renovation.

IV. Proposed Amendments to the Illinois Public Aid Code. (Note: Statutory additions indicated by italic)

A. Declaration of Purpose

Amend Sec. 5–1, second paragraph to read: "Preservation of health, *prevention of disease*, alleviation of sickness, * * *."

Comments: For specific preventive care services for which reimbursement shall be made see amendments to Sec. 5–5 in IV (E) of this report.

B. Classes of Persons Eligible

Amend Sec. 5–2 to include as new subsections. 3 and 4:

"3. Persons otherwise eligible for basic maintenance grants under Article IV but who fail to qualify thereunder on the basis of the full employment of a family wage earner.

"4. Persons otherwise eligible for medical assistance under Section 5–2(2) of this Article V but who fail to qualify thereunder on the basis of the full employment of a family wage earner."

Current subsections 3 and 4 should be renumbered 5 and 6 respectively.

Comment: These amendments are designed to include within the Medical Assistance Program those families now denied ADC–U cash grants because of the full employment of a father as well as those families now denied categorically related medical assistance eligibility for the same reason.

C. Amount and Nature of Medical Assistance

Amend Section 5–4 to read as follows:

"Subject to the subsequent provisions of this Section 5–4, the amount and nature of medical assistance shall be determined by the County Departments in accordance with the standards, rules and regulations of the Illinois Department, with due regard to the requirements and conditions in each case, including contributions from legally responsible relatives.

"In no event, however, shall the Illinois Department establish income eligibility limitations for persons designated in Article V, Sec. 5–2 (2), Article V (new) Sec. 5–2 (4), and Article V (renumbered) Sec. 5–2(5) of this Code of less than 133% of the maximum basic maintenance grant allowed the most needy recipient of a similar classification under Articles III, IV, and VI of this Code.

"The Department shall devise methods of income evaluation that take into account seasonal and other fluctuations in income with the aim of issuing medical assistance coverage to all those who over a year period would qualify on the basis of need for such assistance.

"Determination of income under the provisions of this Section 5–4 shall include no consideration of the assets possessed by the applicant. The Illinois Department may set standards limiting eligibility for medical assistance on the basis of value of assets possessed. Provided, however, that no applicant shall be denied eligibility for medical assistance on the basis of assets possessed unless the value of those assets exceeds 50% of the maximum income allowed any person or

family of a similar classification for medical assistance eligibility under this code. Provided further, that the following assets shall be excluded from consideration: homestead property, one automobile, and such amounts of life, health, accident, property and other insurance as the Department shall determine to be sufficient for the various classifications of persons and families eligible for medical assistance under this code.

"The Department may devise a plan or plans whereby individuals or families found ineligible under the income and asset requirements promulgated pursuant to this Section 5–4 may nonetheless receive financial assistance toward payment of a percentage of medical expenses incurred."

D. Application and Eligibility Determination Procedures

Amend the Public Aid Code to provide as new Sec. 5–5, the following:

"Sec 5–5 Application and Eligibility Determination Procedures.

"The Illinois Department shall by appropriate rules and regulations establish procedures for processing and determining the eligibility of applicants for medical assistance. Such procedures may take any reasonable form but in any event shall include the following provisions:

(1) *Application for medical assistance may be made at any time regardless of the medical condition of the applicant.*

(2) *Each applicant shall be notified within thirty days of the receipt of his application of the approval or disapproval of his application. Each report of a disapproved application shall be accompanied by a written statement setting forth the reasons for disapproval. If eligibility is disallowed on the grounds of excess income or assets, such statement shall specify the nature and amount of the excess.*

(3) *All approved and disapproved applications shall be kept on file for five years by the County Department to which it was submitted.*

(4) *The Department shall recompute eligibility for medical assistance upon submission by a disapproved applicant of receipts for medical expenses incurred. If within the standard period of eligibility granted approved applicants the disapproved applicant shall have expended for medical care funds in excess of his computed excess income or assets, he shall automatically be declared eligible for medical assistance for the duration of the period, and shall be issued a medical assistance card so indicating."*

Note: All subsequent sections of the existing Public Aid Code should be renumbered to account for the insertion of this new Section 5–5.

E. Medical Services

Amend the Public Aid Code to provide

as renumbered Section 5–6 the following:

"Section 5–6. Medical Services.

"The Illinois Department, by rule, shall determine the quantity and quality of the medical assistance for which payment will be authorized, and the medical services to be provided, which *shall* include all or part of the following: (1) inpatient hospital services * * * (13) other diagnostic, screening, preventive, and rehabilitative services; (14) *psychological counselling;* (15) transportation * * * (16) any other * * * healing.

"In determining those services for which payment will be authorized, the Department shall wherever possible include those preventive services such as diagnostic physical examinations, preventive dentistry, psychological counselling authorized above which are most likely to reduce the possibility of later remedial treatment.

"The Illinois Department * * * Section 5–2."

F. Administration

(1) Medical Payment Fund

Amend Section 12–6 to provide at the end of the current section the following:

"The Medical Payment Fund shall be administered by a Medical Payment Bureau under the direction of a Director of Medical Payments to be appointed by the Governor. The Medical Payment Bureau shall perform such duties as are further designated in this Code."

(2) Payment to Medical Payment Fund

Amend Section 12–6.1 to provide as follows:

*"From State appropriations for this purpose, the Illinois Department shall provide for payment into the Medical Payment Fund * * *"*

(3) Payments to the Medical Payment Fund—How Computed—Monthly Medical Capitation Payments

Amend Section 12–6.2 to provide as follows:

"The Illinois Department shall determine the per capita amount necessary to meet the estimated monthly needs of each person duly authorized to receive medical assistance under this Code for such services and supplies as shall be authorized by the Illinois Department pursuant to Section 5–6 of this Code. Such per capita amounts may vary with the age and classification of the eligible recipient. The Illinois Department shall designate for payment into the Medical Payment Fund the monthly per capita amounts so computed and such payments shall be known as monthly medical capitation payments."

(4) Disbursements From Medical Payment Fund

Amend Illinois Public Aid Code to include the following new Section 12–6.5:

Section 12–6.5. Disbursements from Medical Payment Fund.

"Disbursements shall be made from the Medical Payment Fund solely by the Medical Payment Bureau upon authorization by the Director of Medical Payments. The Director of Medical Payments shall authorize disbursements only for the payment of duly submitted medical vendor claims for services rendered or for the payment of medical premiums as hereafter authorized. Duly submitted medical vendor claims shall be paid within thirty days of their receipt by the Medical Payment Bureau. All claims not so paid shall accumulate interest at the rate of 1% per month or fraction thereof. Each person or family for whom a monthly medical capitation payment shall have been credited to the Medical Payment Fund may request that such

capitation payment be paid to any corporation, partnership or other association licensed by the State of Illinois to provide medical or hospitalization insurance or to any association of physicians authorized by the State of Illinois to provide medical services upon payment of a set premium. Such requests shall be automatically granted by the Medical Payment Bureau and the appropriate funds so disbursed. No medical vendor claims shall subsequently be paid for medical services rendered to those for whom monthly medical capitation payments are so disbursed."

(5) Advance Disbursements to Hospitals
Amend Illinois Public Aid Code to include the following new Section 12–6.6:

Section 12–6.6. Advance Disbursements to Hospitals.

"The Director of Medical Payments is authorized to disburse funds in advance of billing to hospitals and other institutions which during the past year submitted valid claims for reimbursement in excess of an average of $25,000 each month. Such advance disbursements may not exceed in amount 50% of the institution's past year average monthly billings."

Note: Current Sections 12–6.5, 12–6.6 and 12–6.7 should be renumbered 12–6.7, 12–6.8 and 12–6.9 respectively.

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(3) Chicago Housing Authority Report, 1967.

Section III. HOSPITAL SITE REPORTS

Eight hospitals were sites of activity for Student Health Project participants. These included the four major purveyors of ambulatory health services in the city of Chicago and four other hospitals. These latter four ranged from small to medium-sized institutions.

One of the major hospitals, Cook County, is the city and county's only public hospital and was established to care for the indigent. The remaining hospitals were all privately controlled, voluntary institutions. All of them were general hospitals. Most of them were located in, or directly adjacent to, predominantly Negro, poor communities.

The types of activities in which the students engaged at the various hospitals included collection of data, interviews with patients, observations of health care delivery systems and, in some cases, participation in the daily work routine of specific departments.

The work the students did will be described in this section. Their reactions to their experiences in the hospitals will be discussed at the end of this portion of the report.

Cook County Hospital

This public institution is the largest general hospital in the city of Chicago with 2,747 beds. It provides care to the indigent primarily, but has been characterized in certain press articles as "the physician to the Negro" in Chicago. It provides ambulatory services at its Fantus Clinic and the students assigned there worked only in this area.

The emergency and admissions area of this hospital sees approximately 1,200 patients each day. About 200 of these are admitted to the hospital, about 200 are referred to Fantus Clinic and the remainder are "seen and advised." (*1*)

The students reviewed all the patients seen on one day in the Fantus Clinic for residence, age, sex, and race. These data are presented in table 1. (These patients had all been accepted for continuing care at Fantus; patients receiving crisis care in the admitting and emergency area were not interviewed.)

Geographic residence in the study was based on the 75 community areas in Chicago. The concept of community areas within the city of Chicago was first delineated more than 30 years ago, through the work of the Social Science Research Committee of the University of Chicago, with the cooperation and concerted effort of many local agencies and the United States Bureau of the Census. (*2*)

The data in table 1 indicate that on the day of the survey, patients came to Fantus Clinic from 60 of Chicago's 75 community areas. However, patients from only seven community areas accounted for 55.7 percent of all the patients seen that day. Four of these seven areas were on the West Side, geographically close to the hospital and three were on the South Side.

As might be expected, since this hospital is primarily established to render care to the indigent, these seven communities are poverty areas, as defined by the Chicago Committee on Urban Opportunity. (*1*)

In addition to the survey of geographic origin, the students conducted interviews with patients, selected at random, from among persons seated in several waiting rooms of about a dozen clinics in Fantus. Approximately 60 patients were interviewed; 86 percent of them were black and all of them had limited economic resources. Less than 10 percent of the respondents were past age 65 years and the remainder were predominantly under 45 years of age.

When asked why they came to Fantus Clinic, a majority of the patients interviewed responded that they had known about the clinic

all their lives or had been "referred" to it. Ten percent came because their care was free. The most frequently stated reason given by patients who only used Fantus Clinic and no other source of medical care was that they lacked money.

A question probing the patient's knowledge of the MA–NG [1] program revealed that 93 percent of the patients queried about MA–NG had never heard of this program for the medically indigent. Only one-third of the patients who are on public aid rolls were aware that their "green card" entitled them to seek care at private hospitals or from private physicians if they so desired.

Over 90 percent of the Fantus patients rated the personal attention they received and the medical competence and continuity of care at the clinic as "good" rather than "generally good or poor." About 85 percent of the respondents thought that physicians at Fantus were really interested in taking care of the poor and a high positive response was also elicited as their perception of the physicians' interest in taking care of Negroes. About two-thirds of the respondents felt that conditions at Fantus Clinic were improving and that steps were being taken to improve conditions. Only 17 percent thought that nothing was being done to improve conditions there.

When queried as to their preference if they had a choice of free care at neighborhood health centers or continued attendance at Fantus Clinic, about two-thirds responded that they would prefer to go to a neighborhood health center. (This is a different response than the one elicited at Presbyterian-St. Luke's Hospital to a similar question.)

The length of time patients had to wait prior to being seen was probed. Waiting time varied from about 1 hour to as much as 8 hours, with 4 hours appearing to be an average waiting period. The length of waiting time posed a major problem for those patients who were employed since they usually lost an entire day from work. However, apparently patients accept this as inevitable since, upon interview, few persons included cuts in waiting time as one suggestion for improving services.

When queried about suggestions for improvement of health services only about half of the patients had such suggestions. These included: all night emergency services in the neighborhoods; better methods of transporting emergencies to hospitals (there is no public ambulance service in the second largest city in the United States); making information about costs at various hospitals available to the public; and cooperative programs with outlying clinical laboratories so that great travel and time would not be required for tests that only take a few minutes. Other improvements that were suggested related more specifically to Cook County Hospital itself. These included better food, air conditioning, better parking facilities and a time payment plan.

The students, in their report, quoted a number of individual comments made by respondents. They ranged from critical to complimentary and a few of them are repeated here:

> On the surface, they're making every effort, but still there's not much being done to improve. Why do people have to come all the way here—20 miles? Why don't they have services there? They pay taxes. Mayor Daley doesn't even say why. These people come and sit after coming 25 miles and sit all day. Maybe don't get any service all day. Why do you have to do it all day? People in pain * * *
>
> To get admitted to the hospital takes a long time unless you have political connections, even if you have a doctor's note. I went and got a note from my alderman and got admitted right away. The system of admissions makes people die. Wait a long time—2 or 3 weeks. Some people suffer. They are people. They're sick.
>
> No place to go, only the County. Police have failed. They won't touch you without a statement from family doc-

[1] Medical Assistance—Non Grant which provides payment for eligible patients from public funds even though they are not on public assistance rolls.

> tor. I know one woman who died. But again I think it's political.
>
> No * * * never get me to complain, they've treated me nice.
>
> Can't be no better. But you do wait, it's so crowded. I don't mind waiting; it's a good hospital.

In comparing patients interviewed at Fantus with a group interviewed at another hospital (see section on University of Chicago clinics) an interesting difference emerged. The students report commented on this difference, as follows:

> Thus we have considerable difference between Fantus and Billings populations, the majority of the former coming because they "have to", the latter seeking out a source of care thought to be superior. * * *

While it is not valid to make a scientific comparison between the groups interviewed, the clinical impression the students gained, as described in the quotation, appears to have merit.

Presbyterian-St. Luke's Hospital

This is the third largest general hospital in Chicago with about 850 beds. It has a long tradition of providing ambulatory and in-patient services to populations of limited means, as well as all other means and groups. Its out-patient clinics (referred to as the health center) served approximately 99,000 patient visits last year. When visits to its recently opened neighborhood health center are added (approximately 35,000 this past year), it becomes the largest purveyor of ambulatory services among the private hospitals in Chicago.

The students at this site worked solely in the health center physically located at the hospital. They were not involved with its neighborhood health center located in a community adjacent to the hospital. These students undertook a survey of the out-patient clinic population and they interviewed some patients at the end of this survey.

The survey of the health center population was based on a sequential sampling technique making it possible to extrapolate these data for the clinic population as a whole. The card of approximately every 15th patient in the active files (about 15,000 in total) was selected and information recovered from this card. These cards are filed by unit (chart) number and assignment of number is completely random. Each new patient, presenting to the hospital or the health center for care, is assigned the next number from the pool.

The information retrieved from the 1,000 cards selected included the geographic residence of the patient, the age, sex, race, clinic of initial admission, and source of payment for medical care.

The information the project students recovered relative to geographic origin is presented in table II. (This table will be referred to again since it also includes the same information for Fantus Clinic and the University of Chicago Clinics.)

The out-patient services of Presbyterian-St. Luke's Hospital are utilized by patients living in 64 of the 75 community areas in Chicago. However, slightly more than 50 percent of all patients come from four community areas. One of these four areas is the one in which the hospital itself is located and the other three are close to the hospital, just west and southwest of it.

The next largest number of patients from a single community area come from a community on the south side of the city. As can be seen in table II, the patients served at this hospital and at Fantus Clinic tend to come from the same community areas. These areas are considered to be deep poverty communities and their populations are predominantly black.

The distribution of variables for Presbyterian-St. Luke's Hospital clinic population is described in table III. Almost half the active patients are under age 18. Almost 75 percent of them are nonwhite and two-thirds of them are female. Greatest utilization is in the pediatrics and OB–GYN clinics, although the medicine clinics were the clinic of admission for almost 20 percent of the population.

Almost half of the population (42.8 percent) had their health services paid for by public funds, i.e., categorical assistance, Medicare or MA–NG. Fifty-four percent paid for their own care based on a low proportion of the actual costs since their financial resources were limited. Approximately 0.5 percent paid for their own care in full. The remainder had other sources for payment of their medical care.

In summary, patients cared for in the health center of this hospital are for the most part poor, in great proportion black, and while they come from all over the city, the majority come from areas very close to the hospital.

After completing the survey of patients' cards, the students proceeded to interview patients, selected at random, with a questionnaire similar to that used in Cook County. Forty-one patients were interviewed by the two high school students working at the site. Twenty-one of these were male, 19 of them were female, and for one, sex was not recorded. While the utilization of the clinics is higher among females, the fact that more males were interviewed probably reflects the fact that the students were both young males, and possibly more comfortable in discussion with other males. This may also partially account for the fact that 37 of the people interviewed were black, as were the students. The other four were white and two of them were Spanish-speaking.

Nine of the respondents were born in Illinois and 23 were born in southern States. One patient was born in Cuba, a second in Puerto Rico, and the other seven were born in different states. Eighteen of the patients had been receiving care at this clinic for less than 6 months while nine had been coming here for more than 3 years. The remaining patients had been coming for periods between these times. Forty-four percent of them said they came to this institution because it had good doctors and 19 percent came because a friend had recommended it.

Thirty used no other source of medical care presently, while two used the neighborhood health center of the hospital. The remaining nine patients used other hospitals occasionally. Twenty-one said they had not used any other source of care in the past and 21 stated they knew of no other sources of care. (A number of these patients lived nearby other major hospitals in the city.) Nine patients indicated they preferred to use this particular hospital.

The responses dealing with their attitudes toward, and perception of, their own and general health care obviously are biased. When they are seated in the institution from which they seek care and when they are approached by people they consider to represent that institution, their answers may well be guarded or may represent what they believe the institution wishes to hear. In that context, the following are the responses dealing with attitudinal and perception questions.

Thirty-seven of the respondents thought the care they received at this hospital was good and two said it was generally good. The other two did not respond to the question. A similar response was elicited to the question pertaining to their attitudes about the quality of the physicians. Thirty-five thought the physicians were good, two said generally good, and four did not respond.

They were asked whether they thought physicians were really interested in taking care of the poor and of Negroes. There was positive response to these two questions with 31 responding that they thought doctors were really interested in caring for Negroes. Only two thought they were not interested in care for the poor with seven holding no opinion, and one not responding. None of the respondents said physicians were not interested in caring for Negroes but seven held no opinion and one did not respond.

They were then asked if they thought this particular hospital was interested in caring for the poor and the positive responses dropped to 24, with 14 holding no opinion and three not responding. To the question did this hospital take interest in caring for Negroes, 26 responded affirmatively, one said he thought it did not, 10 held no opinion and four did not respond.

The positive responses dropped even more when they were asked if they thought private hospitals in general were really interested taking care of the poor or of Negroes. To the former 16 said yes, seven said no, 12 had no opinion and six did not respond. Seventeen said they thought private hospitals were interested in caring for Negroes, five said they thought not, 16 held no opinion and three did not answer the question.

When asked if they would have a preference if the choice were offered them of care in their neighborhood or at this institution, 33 said they would prefer Presbyterian-St. Luke's Hospital. When the question was refined to ask if they had a choice of free care in their neighborhood or care at this hospital, 32 still responded that they would prefer Presbyterian-St. Luke's Hospital.

These patients were also asked if they had any suggestions for improving care or service in the health center. Eleven patients indicated that cutting down waiting time would be an improvement. (More than half said they had to wait between 1 and 3 hours for care.) Twenty-two said they could "think of no way" to improve the services. They were finally asked whether there were any improvements in health care they would like to see in their neighborhoods. Seventeen responded they would like to see more physicians in them; 22 had no suggestions for improvements.

The sample of 1,000 patients, initiated by the students, is being explored in greater depth for diagnoses and other information, that will enable the planners in the institution to determine more effective and efficient methods of delivering health care to selected populations.

University of Chicago Hospitals and Clinics

This facility is located on the south side of Chicago and the clinics are part of the fourth largest hospital complex in the city (661 beds). It is located directly adjacent to one of the most densely populated Negro communities in the city.

Students working there conducted a survey of utilization of the out-patient clinics and of the Billings Hospital emergency room. They also conducted interviews with randomly selected patients using the same questionnaire as that used at Cook County Hospital.

The period of time for which the review of records was undertaken was not described in the students' report. They reviewed the records of 346 patients who received care in the following clinics: Medicine, OB–GYN, pediatrics, eye, E.N.T., plastic surgery, urology, orthopedic surgery, psychiatry, general surgery, and neurosurgery. They collected information about the geographic residence of these patients, their age, sex, race, and source of payment for medical care. Table II presents the data for geographic residence.

The largest single group of patients (22.5 percent) surveyed came from outside the city of Chicago. The remainder were from 55 community areas of Chicago's 75, and five of these community areas accounted for 30 percent of the total number of patients reviewed. These five areas are all on the south side of the city, directly adjacent to, or relatively near the hospital. Two of them are considered poverty areas and three are nonpoverty areas.

The distribution of variables for all the patients are presented in table IV. Unlike the two other hospitals described so far, 71 percent of the patients pay for their own care. Only 15 percent are paid for by public funds, including Medicare.

The distribution of variables by clinic is presented in table V. The largest number of patients use the medicine clinics, with OB–GYN being the second most utilized clinic. The distribution by race varies from the patients attending the medicine clinics, the majority of whom are white as compared to the OB–GYN and pediatrics clinics where the majority are Negro. Patients utilizing all other clinics are also predominantly white. The out of city patients probably account for this since the five community areas with the greatest utilization for Chicago patients are either all black or have large Negro populations.

After completion of their survey the students conducted interviews with patients, se-

lected at random, from among those seated in the waiting rooms of the medicine, surgery, OB–GYN, and pediatrics clinics. The interviewers approached the patients, without introduction by clinic staff personnel, and described themselves as working for the Student Health Organization and the Hospital Planning Council (collection of data in the University of Chicago clinics was supervised by the research director of that agency). They described these two organizations as being interested in knowing how patients felt about different hospitals in Chicago. They especially attempted to assure the patients that they did not represent a particular hospital, newspaper, school, or doctors' group.

There were 66 patients interviewed. Twenty-five of these were members of families with incomes below $5,000 per annum, 31 had incomes between $5,000 and $10,000 and 10 had incomes above $10,000. There were 44 Negro patients and 21 white patients.

About 10 percent of the patients were supported by public assistance sources. However, in all the interviews about 90 percent had never heard of the MA–NG program or Medicaid, per se. The few who had heard about it knew no more than its name.

Fifty-five percent of the patients used no other health resources besides the University of Chicago Clinics for themselves or their families. More than 50 percent of the patients stated that they attended Billings because it had been recommended to them or because it had "good doctors."

Waiting time in the clinics varied between clinics. The longest waits were in the medicine and surgery clinics while there were only short delays in seeing patients in pediatrics and obstetrics clinics. Those who generally waited longer than 1 hour were the ones who stated that a way to improve the service was to cut down the waiting time or add more staff. However, a number of people did not appear to object to the waiting periods.

Their loyalty to the institution appeared to be on a high level; approximately 40 percent indicated they would depend on the institution for emergency care or for other medical reasons regardless of its distance from their homes or other factors.

The attitudes of the patients were probed relative to their perceptions of the hospital's interest in caring for poor people, and Negro people. About 20 percent of the patients thought that physicians were not really interested in taking care of the poor and 20 per cent thought that physicians in their neighborhoods were not interested in caring for people living in their neighborhood. About 40 percent thought that private hospitals were not interested in taking care of the poor or in Negroes. When the question was refined as to whether this particular hospital at the University of Chicago was interested in taking care of the poor, all but six responded they thought it was so interested and only two felt that the hospital was not interested in taking care of Negroes.

The students selected several comments on these latter subjects from the people who were interviewed that are worth repeating there as they project an interesting variety of attitudes.

> * * * I can afford medical care and if it's free it should serve the people who can't afford to pay for it.
>
> Too much attention paid to poor blacks now. They (the poor) don't know the difference. Too many (Negroes) but they have to live, too, I guess.
>
> * * * They (the welfare patients) shouldn't be here if they cannot pay. Public aid should set up a place especially for those people. It's unfair to let those welfare people come here. I don't think transportation is too bad and there are all the health stations.
>
> The fees are too high. The government shouldn't regulate prices but everybody should be able to get good care and the government should pay for schooling of more doctors.

As the survey indicated, not only are there major differences between the patients who utilize the University of Chicago hospitals and

the other two described, in terms of income, race, etc., there are also differences in attitudes of patients toward key social and health questions.

Woodlawn Hospital

This is a small hospital (145 beds) located in the heart of a Negro community on the south side of Chicago. There are no out-patient clinic services and the work performed by the assigned students included a survey of in-patient and emergency room utilization.

The data for in-patient utilization, by community of residence, is described in table VI. The data are for 1 year's experience. Three community areas account for 37.7 percent of the patients admitted in this 1 year. These are the communities in which the hospital itself is located, the one directly north and the one directly south of its physical plant. One of these (Woodlawn) is a poverty area, the other two are not.

Five other community areas account for 18.5 percent of the annual admissions. Three of these are further south of the hospital and two of them are north of it. None is far away geographically. Four of these are poverty areas and one is not.

Another 17 percent of the patients come from nine community areas. There were 50 or more patients from each who were admitted that year. Four of these were poverty areas and five were not.

Patients from outside the city accounted for an additional 8 percent of the patients.

There has been a change in the geographic distribution of admissions from 1965. Medical-surgical services admissions to Woodlawn Hospital in February 1968 compared with that in February 1965 revealed that admissions from the Woodlawn area (where the hospital is located) increased by 70.7 percent from 1965—8.2 percent in that year and 14.0 percent in 1968 admitted from the area. The change for the rest of the southeast section which Woodlawn serves was not as dramatic. In this case, 29 percent of the patients admitted in February 1965 were from that area and in 1968 37.5 percent were from that area, an increase of 29 percent.

The students reported that they felt the major reason for this change resulted from changes in payment policies of the welfare department. They said:

> Until 2 years ago the attending physician was not paid for his services to welfare in-patients although the hospital did receive payment for hospital costs. With the change in payment policy that occured in 1966, the hospital staff physicians began to refer welfare recipients to the hospital. * * *

They felt other factors were:

> An increase in the resistance of Cook County Hospital toward admitting patients transferred from other hospitals and an increased reluctance of the emergency room physicians to transfer border line cases has resulted in a rise of admissions to Woodlawn Hospital from its emergency room. * * *

The final point they make as to reasons for the change, is:

> An administrator with a greater awareness of a need for a responsible attitude toward the community, assisted by a hospital staff with a changing outlook, may also have contributed substantially to bring about the increase in admissions from the community surrounding the hospital.

The study of emergency room patients consisted of observations of the functions of the emergency room and telephone interviews of 30 patients who had been treated there. The reaction of the students was that there were two major problems in emergency room function. First, a large percentage of the emergency room visits were not genuine emergencies and secondly the inability of many of the patients coming to the emergency room to pay for their medical care resulted in problems for the patients.

The first observation is, of course, one that many emergency rooms in urban centers are concerned about, i.e., their utilization as a physician to the nearby community(ies), instead of their utilization as true emergency centers.

In their second observation, the students noted that the great majority of emergency room patients were either on public assistance or were unable to pay for their care. In the latter case, if a patient was not on categorical assistance or Medicare, a financial deposit was required prior to admission unless he was extremely ill and absolutely could not be transported. In less extreme cases, patients without a source of payment, were generally transferred to Cook Country Hospital if the transfer was accepted (as it usually is). Here again, this situation is repeated many times in hospitals around the city, and doubtless in other cities around the country.

The students conducted telephone interviews with 30 patients.

Twenty-two of the 30 questioned chose to come to Woodlawn because it was closest to their homes. Twenty-five thought it was a good hospital. Nineteen patients stated that they had private doctors, while 11 did not. Eleven of the 19 said that they went to their private physicians regularly.

They were also asked for their opinions as to the best place for health care and 12 thought Woodlawn Hospital was, five thought Cook County was and only seven thought a private physician was the best source of health care. Four of the remaining six had no opinion on the subject.

Thirteen of the patients reported they paid for their medical care themselves and three had insurance coverage for such costs. The remaining 14 were eligible for public funds including Medicare.

Apparently, loyalty to the health purveyor of choice, even when the choice is made primarily by geographic location, remains high. This appears to be true for this small hospital as well as for the major ones referred to previously.

Michael Reese Hospital

This hospital is the largest private hospital (933 beds) and second largest hospital in Chicago. Its out-patient clinics serve approximately 115,000 patient visits per year.

The hospital is located on the edge of a black and poor community. Indeed, at one time the hospital itself was part of such a community. However, urban renewal changed the character of the neighborhood immediately surrounding the hospital. Now much of the land is used by educational and medical institutions, including Reese's expanded facilities, and the remainder of the immediate community consists of high rise apartment buildings for middle and upper middle income population.

Students at this site reviewed data on clinic utilization by community area. They also worked in the pediatric out-patient clinic where a new mode of delivery of health care had been instituted in the immediate past. (New, in the sense that it was a change from their previous mode of delivery.) In addition they surveyed charts in the emergency room, again reviewing for utilization data by areas of residence.

The students undertook a review of 500 charts of patients seen in the outpatient clinics (excluding pediatrics) in June of 1968. Unfortunately, they did not conduct a citywide tabulation of the clinic's population. Instead, they collected the information pertinent to the numbers from four community areas close to the hospital. Their figures indicated that 205 (41 percent) of the 500 charts represented people living in those four areas. A separate survey of 217 charts in the pediatrics clinics showed that 91 (42 percent) of these patients came from the same four areas. In 485 emergency room records, 274 (56.5 percent) patients were from the four areas. It is apparent that an important segment of the population served by the ambulatory facilities of this hospital reside in the four community areas adjacent to the site of the hospital. One of them is the one in which the hospital itself is peripherally located; the other three are just southeast and southwest of it.

The students also reviewed in-patient admissions for the community areas from which they came. They reported that of 1,791 discharged patients, only 10.2 percent came from the four community areas discussed.

The students who worked in the pediatrics clinics described changes made by the hospital administration which emphasize the delivery of preventive care as well as continuing to deliver crisis or symptom-oriented care.

The new organization of the pediatrics clinics was described as based on an appointment system. Patients were screened and referred to the appropriate source of care. They were then assigned a specific physician whom they are supposed to see each time they come. Blocks of time in the appointment system are left unscheduled so that physicians may also see walk-ins. A telephone service (TOT line) is now available to parents. The parent may call in at any time of day or night. A nurse monitors this telephone and acts as a screening officer. She determines the nature and seriousness of the problem, acts in a reassuring fashion, if indicated, and makes a judgment as to the disposition of the problem.

Another innovation for this unit is a terminal collection of fees system. Previously, patients paid for each service at the point where or when the service was rendered. If more than one service was rendered the patient paid more than one time. The current system permits the patient to pay once at the termination of all his clinic services.

The physical environment has been made more attractive and comfortable; more equipment is available; and additional nonprofessional staff have been employed to expedite processing of patients.

While this learning experience seemed to be a positive one for the students nonetheless they were critical of problems that still remained to be solved. Several quotations from their reports would be in order:

> * * * One of the greatest difficulties that this program began with and is constantly hampered by is the background of a staff which is accustomed to working within a framework of administration-centered medical care when the new orientation and structure of the clinic is patient-centered* * * however, the persistance of the old attitudes in the staff prevents there being any significant change in the attitudes of the patients being served * * * there hasn't been a tremendous change in the parts of the system which the patients find irritating, e.g., waiting time, hurried care by doctors, treatment by the staff, bewilderment and lack of communication * * *. Much of the discontent remains because the new system is a new stone in the same old setting. Patients must still wait for lab reports, X-ray results, shots, pharmacy services * * *.
>
> However, the strengths of the new approaches are also described:
>
> "There are at least three great virtues * * *. First, the clinic is capable of and is providing better and more dignified care to more people because of increased manpower, longer hours, and the physical changes * * *. Second, the clinic provides an experimental milieu in which not only new methods of providing care can be studied, but also the fairly new concept of studying methods in physician education * * * finally, this clinic, and in particular, the new comprehensive care clinic provides an excellent model * * * of some of the new concepts in private or rather general practice * * *.

All of the students at this site were complimentary to the staff and administration of this institution as being a progressive, enlightened group who were seriously concerned with delivery of health care to poor populations.

Provident Hospital

This is a hospital with a predominantly

Negro staff and almost all Negro patients. It is located in the heart of one of Chicago's largest Negro ghettoes. It is a small hospital with 204 beds which has been struggling for many years to maintain itself. It has had to close its out-patient facilities for lack of funding as well as having been forced to close its nursing school and internship and residency programs. Despite many obstacles and lack of support it continues to provide care for a substantial segment of the black population.

The students at this site were involved in service roles as well as observation and data collection. The health science student worked in the blood bank facilities and occasionally assisted the technicians when they had heavy work loads. The high school students participated in a number of unskilled jobs in the hospital.

The students also worked in an educational program in the community disseminating information about lead poisoning. The residents of this particular community are involved in a campaign for passage of an amendment to the city housing code that will provide some safeguards against lead poisoning. However, no major involvement on the part of the hospital for a lead toxicity detection program was feasible.

The suggestions for closer relationship of the hospital with its surrounding community are quoted from the student's report:

> I know only to give it enough money to expand its facilities, reopen its clinics, reestablish its nursing school, attract residents and interns and then younger doctors * * * put residents of the community on its board and on its policy determining committees * * *

EMERGENCY ROOMS

Mercy and Billings Hospitals

While students actively participated in interviews with patients using emergency rooms in six of the hospitals, specific data about some of the parameters of the populations was recovered for only two of them. These were the emergency rooms of Mercy and Billings Hospitals. Billings has been described previously in the section on the University of Chicago Hospitals. Mercy is a church-related (Roman Catholic) institution of 355 beds. It has out-patient clinics as well but no students were placed there. It is located on the near south side of Chicago in what was a poor Negro community. Urban renewal has changed some of the characteristics of the community but the hospital is still most closely adjacent to all black, generally poor communities.

At Mercy Hospital, during one week in August, 1968, every third patient who used their emergency room was tabulated for community area of residence, age, sex, race, source of referral, time of arrival, diagnosis, disposition, and source of payment for care. Similar data were gathered for the Billings emergency room using one week in April, 1968 as the base.

Data for area of residence of patients using both facilities are described in table VII. Data relative to variables appear in table VIII.

The largest numbers of patients from any one community area using Mercy were from the community of Bridgeport. This part of the city is composed of people of different ethnic backgrounds but is all white. It is primarily a working and middle class community and is located slightly south and west of the hospital. A large proportion of its residents are communicants in the Roman Catholic Church. (It is also the home of the mayor of the city of Chicago). The next largest number came from the all black communities of Grand Boulevard (CA 38) and Douglas (CA 35) both of them to the south of the hospital.

Unlike the population utilizing the University of Chicago clinics, the largest number of patients coming to Billings emergency room were from Woodlawn (25.5 percent), the area directly south of the hospital (across the Midway). The second largest group came from Hyde Park just north of the hospital. It would appear that in the utilization of these emergency rooms, geography is still a major factor.

That many patients use the geographically convenient emergency rooms as doctors' offices

is supported by the data relative to diagnoses of patients, disposition of cases, and time of arrival at the facility. (See table VIII.) In both hospitals' emergency rooms, the majority of patients were treated for general medical problems and sent home. The next largest group was referred for care to the hospitals' out-patient clinics and the third largest group were referred to other hospitals or doctors. In both hospitals, fewer than 10 percent of the patients seen were admitted to the hospital for care.

Time of arrival at the emergency room indicates that their experience is the same as that in many urban emergency rooms. The peak load is after 5 p.m. and prior to midnight. This would seem to support the contention that patients tend to come to such facilities when transport is more readily available at the end of a work day or when some source of care is more readily available for children left at home.

The source of payment for medical care was not available for the Billings patients. It would have been interesting to note whether the source in Billings emergency rooms, with its substantial numbers of patients from Woodlawn, was different from the source of payment for patients who use the University of Chicago clinics for ambulatory care.

The majority of the patients seen at Mercy (59 percent) were insured and the second largest group paid for their own care. Only 19 percent were supported by public funds.

St. Bernard's Hospital

This hospital is a 229 bed Roman Catholic Church related institution located on the south side of Chicago further south than the others reported on so far and slightly west of them.

Students working in their emergency room described themselves as "participant observers." The major objective as they defined it was to observe and gain impressions of what happened in the emergency room. A second objective was to interview patients to determine the patients' impressions of what happened in an emergency room.

They elected not to use a structured questionnaire for the latter task since they felt there were too many forms a patient had to fill out in the course of hospital routine without adding another. Some patients were interviewed in the emergency room area but others were interviewed by telephone or at their homes. This latter technique was selected to determine reactions after the stress situations that brought the patient to the hospital had been removed or ameliorated. When the students conducted interviews in the hospital area they sometimes wore white uniforms and permitted the patients to view them as hospital staff. However, in some cases they simply described themselves as Student Health Organization students with no vested interest in the hospital. Their feeling was that their image in the patient's view did little or nothing to change the nature of the responses.

The patients interviewed in the hospital were quietly accepting of the interview and cooperative. One of the employees pointed out subsequently that the patients were very humble and fearful while in the hospital setting. However, once the site of the interview was the home of the patient, the students met with great suspicion and distrust and had much difficulty in locating and interviewing the patients.

The students at this site also acted as "patient advocates." This was defined as assisting the patients in any way they could. They helped patients find their way to the services needed; they intervened with an administrator on behalf of a patient who felt he should be refunded a fee since no service was rendered him; and they helped a patient to another source of care when he was referred to it. Having learned some things themselves about how to move through the maze of a hospital system, they were able to ease the paths of patients without similar knowledge.

There was one other emergency room in a hospital in Chicago which was not originally selected as a site. However, a student was there on the night shift to informally observe their emergency room procedures. This was a hospi-

tal which contracted with a corporation to employ physicians to staff the emergency room. While some of these agencies provide good emergency room staffing, it was the observation of this individual student that this particular one did not.

The student felt that with the difficulty of obtaining qualified physicians, most of those working a night shift did so as a second position. Therefore, in his opinion, they are frequently very tired and there is an underlying hostility to patients, especially those whom they feel are not genuine emergencies. He thought that there was no ongoing relationship between such a physician and his patient and that this affected the type of care rendered the patient.

In the observer's view:

> "The staff never attempts to deal with problems considered outside its province. It is only interested in reaching decisions about the following * * * (1) Discovering the chief complaint of the patient; (2) rendering symptomatic relief as well as first aid and supportive care in true emergencies; this facility renders "advanced first aid," (3) determining whether it is absolutely necessary to admit indigent patients. Most indigents are sent to Cook County * * *. In general, indigents receive an absolutely minimal amount of care."

The student indicated that this hospital's patient area is in excellent physical condition and on very busy nights the area is often filled with patients. The atmosphere, at night, he found to be generally friendly. There appeared to be a rigidly structured relationship pattern with little or no overlap of function, between the different strata of personnel, i.e., physician, nurse, technician. One of the reasons for this the student thought was that the physicians were under the supervision of the outside contracting agency, while the hospital administrator supervises the other personnel.

He felt there was evidence that the administrator is interested in improving efficiency of the area and that the hospital is much concerned with its public image.

Student Reaction

At the end of the summer's work each student wrote a report on his activities during the project. There was a uniformity of reaction among the students at all the hospital sites. In each case the students reported that they had had an important learning experience personally; in almost all cases the students questioned whether they had contributed anything to their site or to the project as a whole. Even those who felt they had made some contribution considered it to be a negligible one. An objective review of all the report, indicates however, that their microcosmic, subjective view is not wholly accurate. It is understandable, but not accurate.

As has been stated elsewhere, this was a 10-week project. In almost all of the hospital sites, a period of from 1 to 3 weeks was devoted to orientation of the students. The last week was a windup week. This left 6 or 7 weeks for the students to actually become involved in the work at their site. Some of the students recognized that this time dimension limited their effectiveness but others appeared to have had higher goals than might have been realistic.

Uniformly the students were critical of the modes of delivery of health care that they observed in the institutions in which they worked. (All of their experiences were limited to ambulatory service areas.) Their comments ranged from friendly, respectful observations to hostile declarations.

Some selected quotations from a few reports might highlight the range of critical comment:

> * * * We choose not to evaluate such a * * * center on the basis and in terms of its own inherent inadequacies however, for we have not the medical, institutional, or practical resources to justify such a discourse, nor can we underestimate the professional competence and vigor with which these inadequacies are now being at-

tacked. We choose rather to air a more general commentary that relates these inadequacies to the more general problems which confront medicine today and to those more pervasive ones deeply rooted in the whole fabric of our society * * *

* * * We spent sometime trying to determine what forces constrain the emergency room to be inadequate. This attempt has been generally unsuccessful * * * In retrospect, we have devoted our time to the most important of the answerable questions, but it is the unanswerable questions which are most interesting * * * we have had complete cooperation from the hospital, and are on a friendly basis with the administration and emergency room personel. * * *

* * * We became aware of some of the advantages and disadvantages of the small inner-city hospital. Among the advantages were a greater feeling of "belonging" experienced by hospital employees and patients, and an administration shielded by a minimal bureaucracy. Among the disadvantages were that many of the services were inefficient* * * * as they involved expensive equipment infrequently used, and the difficulty in attracting young physicians with larger institutions nearby * * *.

There were several unfriendly comments. Some of these were as follows:

* * * If patients receive good medical care it isn't so much due to the dedicated staff * * * but to the intervention of the administrator * * * We object to the fact that medical care should depend on the humaneness of one individual. It is a right, not something administered condescendingly * * *"

* * * * The patients may wait up to 3 hours on a busy night, especially if the physician is tired, which is usually the case * * * The underlying attitude of the night staff toward the patients is one of hostility * * *. The staff is especially hostile toward patients who enter the facility without true emergency needs * * *."

One other comment:

* * * The doctor's divorce from the community is mirrored by the community's reaction to it. The mothers I talked to are adamantly opposed to taking their children there * * *.

One statement, more general in nature, is a creditable summation of the views of the students:

Health care planning seems to have rarely taken account of the felt needs of the patients who are to be served. When the patient population is generally white middle class there are fewer "problems"—the health planners themselves being of this milieu, have the same expectations and concepts of health care, health and disease. When the patient population is, for example, Appalachian white, Mexican, Puerto Rican, poor urban black, middle class black, etc. it is entirely possible that the white middle class standards and expectations of health care, concepts of disease, the role of the doctor etc.—all that which is built into the typical urban hospital or neighborhood health center—do not conform to those standards, expectations, etc. of the patient population. The result is very possibly a relative failure of the program."

Summary

Students working in hospital sites acted as observers in emergency rooms and out-patient clinics to learn how health care is purveyed to primarily poor, black populations. At a number of sites, they collected data relative to patient utilization of clinics and emergency rooms for area of geographic origin, race, sex, and other

variables. They acted as patient advocates in some cases and participated in service roles in others. Uniformly, they were critical of modes of delivery of health care services to the population observed. They felt that there was little or no impact resulting from their presence in the summer project.

Actually, when they detailed their experiences in their respective projects, it appeared that they had successfully completed their assigned tasks in most instances. They had made a contribution to several institutions in the work they undertook. In all cases, they felt that their summer's experience in the Student Health Project had been a profound learning one for them and that its impact upon them would have important implications for their future career goals.

Table I.—Outpatients attending Fantus Clinic, Cook County Hospital, by community of residence, July 24, 1968

Community	Sex		Age				Race		
	Male	Female	Under 15	15 to 44	45 to 64	65 and over	White	Negro	Other
1A Rogers Park A	------	1	------	------	------	1	1	------	------
1B Rogers Park B	1	------	------	1	------	------	1	------	------
2 West Ridge	------	1	------	------	------	1	1	------	------
3A Uptown A	1	------	------	1	------	------	------	------	1
3B Uptown B	4	4	------	4	4	------	7	1	------
4 Lincoln Square	------	------	------	------	------	------	------	------	------
5 North Center	2	------	------	1	------	1	1	1	------
6A Lake View A	------	------	------	------	------	------	------	------	------
6B Lake View B	4	4	1	4	1	2	8	------	------
7A Lincoln Park A	1	------	1	------	------	------	------	1	------
7B Lincoln Park B	2	1	------	2	------	1	1	1	1
8A Near North A	1	------	1	------	------	------	1	------	------
8B Near North B	17	11	4	15	6	3	7	20	1
9 Edison Park	1	------	------	------	1	------	------	1	------
10 Norwood Park	------	1	------	------	------	1	1	------	------
11 Jefferson Park	------	------	------	------	------	------	------	------	------
12 Forest Glen	1	------	------	------	------	1	1	------	------
13 North Park	------	------	------	------	------	------	------	------	------
14 Albany Park	1	1	------	1	1	------	1	1	------
15 Portage Park	3	------	1	1	------	1	2	1	------
16 Irving Park	1	1	------	------	------	2	2	------	------
17 Dunning	1	------	------	------	1	------	1	------	------
18 Montclare	------	------	------	------	------	------	------	------	------
19 Belmont Cragin	------	------	------	------	------	------	------	------	------
20 Hermosa	------	------	------	------	------	------	------	------	------
21 Avondale	2	------	------	2	------	------	1	------	1
22 Logan Square	7	6	1	4	3	5	10	2	1
23 Humboldt Park	6	6	2	6	2	2	4	6	2
24 West Town	12	10	------	9	9	4	16	4	2
25 Austin	11	5	3	8	5	------	7	9	------
26 W. Garfield Park	25	28	16	27	5	5	3	50	------
27 E. Garfield Park	32	40	23	34	8	7	4	67	1
28 Near West Side	67	50	26	48	30	13	17	95	5
29 North Lawndale	62	47	45	38	19	7	5	103	1
30 South Lawndale	4	1	------	2	1	2	3	------	2
31 Lower West Side	3	3	------	2	2	2	3	2	1
32 Loop	6	1	1	2	2	1	4	2	------

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	Community	Sex		Age				Race		
		Male	Female	Under 15	15 to 44	45 to 64	65 and over	White	Negro	Other
33	Near South Side	2	3	2	1		2		5	
34	Armour Square	2	1	1	2				3	
35A	Douglas A	1	1	1		1			2	
35B	Douglas B	15	19	8	16	7	3	2	31	1
36	Oakland	12	8	3	8	7	2	1	19	
37	Fuller Park	3	7	2	5	3			10	
38	Grand Blvd.	55	51	22	44	25	15	3	101	2
39A	Kenwood A	1	1	1	1			1	1	
39B	Kenwood B	6	6	3	7	1	1	2	10	
40	Washington Park	24	31	8	26	13	8	1	53	
41A	Hyde Park A	1	1		1		1		2	
41B	Hyde Park B	1	5		4	1	1		6	
42	Woodlawn	24	20	11	18	12	3		44	
43A	South Shore A	2	5		3	3	1		6	1
43B	South Shore B	3	7	3	4	2	1	1	9	
44	Chatham	8	8	4	5	3	4	2	14	
45	Avalon Park	2	1	1	2				3	
46	South Chicago	5	5	1	6	1	2	2	7	1
47	Burnside	1				1			1	
48	Calumet Heights		1		1			1		
49	Roseland	4	4		3	3	2	2	6	
50	Pullman									
51	South Deering									
52	West Side									
53	West Pullman									
54	Riverdale	8	6	4	7	2	1	1	13	
55	Hegewisch	1				1			1	
56	Garfield Ridge		2		2				2	
57	Archer Heights									
58	Brighton Park		2			2		1	1	
59	McKinley Park									
60	Bridgeport	3	2	1	2		2	4	1	
61	New City	1	5	1	4		1	1	5	
62	West Elsdon	1				1		1		
63	Gage Park									
64	Clearing									
65	West Lawn		1		1			1		
66	Chicago Lawn		2	1		1		1	1	
67	West Englewood	15	11	8	14	4		4	22	
68	Englewood	26	47	11	42	15	5	6	66	1
69	Grand Crossing	17	13	7	12	5	6	2	27	1
70	Ashburn		1			1		1		
71	Auburn Gresham	7	7	8	3	2	1	2	12	
72	Beverly	2					2	2		
73	Washington Heights	2	3	2	3		1	4		
74	Mount Greenwood									
75	Morgan Park	3	6	2	3	3	1		9	
	Total	536	514	241	462	220	126	159	864	27
	Total percentage			23	44	21	12	15.1	82.3	2.6

TABLE II.—*Community area of residence, outpatients attending Fantus, University of Chicago and Presbyterian-St. Luke's Hospital Clinics*

	Community area (number and name)	Fantus [1]	University of Chicago [2]	Presbyterian-St. Luke's Hospital clinics [3]	Total
1	Rogers Park	2	2	1	5
2	West ridge	1	3	0	4
3	Uptown	9	1	1	11
4	Lincoln Square	0	1	6	7
5	North Center	2	0	0	2
6	Lake View	8	3	2	13
7	Lincoln Park	4	0	6	10
8	Near North	29	1	21	51
9	Edison Park	1	0	0	1
10	Norwood Park	1	0	0	1
11	Jefferson Park	0	0	1	1
12	Forest Glen	1	0	0	1
13	North Park	0	0	1	1
14	Albany Park	2	2	3	7
15	Portage Park	3	2	2	7
16	Irving Park	2	1	3	6
17	Dunning	1	1	3	5
18	Montclare	0	0	0	0
19	Belmont Cragin	0	0	2	2
20	Hermosa	0	0	0	0
21	Avondale	2	1	2	5
22	Logan Square	13	0	14	27
23	Humboldt Park	12	1	14	27
24	West Town	22	5	31	58
25	Austin	16	1	35	52
26	W. Garfield Park	53	0	92	145
27	East Garfield Park	72	1	137	210
28	Near West Side	117	2	150	269
29	North Lawndale	109	3	123	235
30	South Lawndale	5	1	12	18
31	Lower West Side	6	0	17	23
32	Loop	6	1	4	11
33	Near South Side	5	1	4	10
34	Armour Square	3	1	4	8
35	Douglas	36	5	12	53
36	Oakland	20	1	4	25
37	Fuller Park	10	0	4	14
38	Grand Boulevard	106	6	31	143
39	Kenwood	14	4	6	24
40	Washington Park	55	13	14	82
41	Hyde Park	8	29	1	38
42	Woodlawn	44	27	18	89
43	South Shore	17	23	4	44
44	Chatham	8	14	19	41
45	Avalon Park	3	2	1	6
46	South Chicago	10	6	1	17
47	Burnside	1	0	1	2
48	Calumet Heights	1	7	5	13
49	Roseland	8	9	7	24
50	Pullman	0	0	2	2
51	South Deering	0	4	0	4
52	East Side	0	1	1	2
53	West Pullman	0	4	2	6
54	Riverdale	14	1	2	17
55	Hegewisch	1	0	1	2
56	Garfield Ridge	2	1	4	7
57	Archer Heights	0	0	1	1
58	Brighton Park	2	3	2	7
59	McKinley Park	0	0	2	2
60	Bridgeport	5	1	6	12
61	New City	6	3	8	17
62	West Elsdon	1	2	1	4
63	Gage Park	0	3	3	6
64	Clearing	0	1	0	1
65	West Lawn	1	0	1	2
66	Chicago Lawn	2	5	4	11
67	West Englewood	26	4	20	50
68	Englewood	73	6	40	119
69	Grand Crossing	30	20	15	65
70	Ashburn	1	5	1	7
71	Auburn Gresham	14	9	14	37
72	Beverly	2	2	0	4
73	Washington Heights	5	7	6	18
74	Mount Greenwood	0	1	0	1
75	Morgan Park	9	4	5	18
	Out of City	0	78	40	118
	Total	1,050	346	1,000	2,396

[1] One day's experience, July 24, 1968.
[2] Unknown time period.
[3] Sequential sampling total active clinic population.

TABLE III.—*Presbyterian-St. Luke's Hospital Clinic Population*

Variables	Number
Age:	
0 to 5 years	165
6 to 12 years	152
13 to 18 years	130
19 to 34 years	248
35 to 64 years	221
65 years and older	84
Total	1,000
Sex:	
Male	339
Female	661
Total	1,000
Race:	
White	233
Negro	722
Spanish-speaking	36
Other	9
Total	1,000
Initial clinic of admission:	
Medicine	195
Pediatrics	358
Surgery	106
Surgery subspecialties	81
Obstetrics and gynecology	216
Psychiatry (adult and child)	41
Other	3
Total	1,000
Source of payment for medical care	
Self (full pay)	5
Self (part pay)	540
Public assistance	428
Medical assistance—no grant	9
Other sources	18
Total	1,000

TABLE IV.—*University of Chicago clinics*

	Number	Percent
Age:		
0 to 16 years	56	16.2
17 to 40 years	132	38.1
41 to 64 years	116	33.6
65 and over	39	11.3
Not known	3	.8
Total	346	100
Race:		
White	193	55.7
Negro	139	40.1
Other	12	3.5
Not known	2	.6
Total	346	100
Sex:		
Male	135	39.1
Female	211	60.9
Total	346	100
Source of payment:		
Medicare	38	11
Other public fund	15	4.3
Insurance	26	7.5
Self-payment	247	71.3
Not known	20	5.8
Total	346	100

TABLE V.—*University of Chicago clinics: Distribution of variable by clinics*

		Age				
Name of clinic	Total	0 to 16 years	17 to 40 years	41 to 64 years	65 years and over	Not known
Medicine	107	0	28	52	26	1
Pediatrics	18	18	0	0	0	0
Obstetrics and gynecology	62	11	37	14	0	0
Surgery	16	0	7	7	2	0
Neurosurgery	3	0	1	2	0	0
Plastic surgery	5	1	3	1	0	0
Urology	14	1	6	5	2	0
Orthopedics surgery	24	3	14	6	1	0
Eye	25	8	9	5	3	0
Ear, nose, and throat	26	4	6	15	1	0
Psychiatry	22	1	16	5	0	0
Dermatology	13	1	2	4	6	0
Nutrition	5	0	0	5	0	0
Unidentified	6	0	2	4	0	0
Total	346	48 (13.9)	131 (37.9)	125 (36.1)	41 (11.8)	1(.3)

Sex

Name of clinic	Male	Female
Medicine	52	55
Pediatrics	8	10
Obstetrics and gynecology	0	62
Surgery	5	11
Neurosurgery	0	3
Plastic Surgery	4	1
Urology	8	6
Orthopedic Surgery	11	13
Eye	11	14
Ear, Nose and Throat	11	15
Psychiatry	15	7
Dermatology	7	6
Nutrition	0	5
Unidentified	3	3
Total	135 (39.0)	211 (61.0)

Race

Name of clinic	White	Negro	Other
Medicine	61	38	8
Pediatrics	4	14	0
Obstetrics and gynecology	18	42	2
Surgery	13	3	0
Neurosurgery	3	0	0
Plastic surgery	4	1	0
Urology	7	7	0
Orthopedic surgery.	13	11	0
Eye	13	9	3
Ear, Nose, and Throat.	20	6	0
Psychiatry	22	0	0
Dermatology	10	2	1
Nutrition	1	4	0
Unidentified	4	2	0
Total	193 (55.8)	139 (40.2)	14 (4.0)

Source of payment

	Medicare	Other public	Insurance	Self pay	Unknown
Medicine	27			80	
Pediatrics					18
OB-GYN		15	26	19	2
Surgery	2			14	
Neurosurgery				3	
Plastic surgery				5	
Urology	1			13	
Orthopedic surgery	1			23	
Eye	2			23	
Ear, Nose and Throat	1		1	25	
Psychiatry				22	
Dermatology	4			9	
Nutrition				5	
Unidentified				6	
Total	38 (11.0)	15 (4.3)	26 (7.5)	247 (71.4)	20 (5.7)

TABLE VI.—*Woodlawn Hospital: Inpatient admissions July 1, 1967 to June 30, 1968*

	Community area (number and name)	Number of admissions	Percent [1]
1	Rogers Park	16	0.4
2	West Ridge	7	.2
3	Uptown	26	.7
4	Lincoln Square	1	.03
5	North Center	0	----
6	Lake View	14	.4
7	Lincoln Park	11	.3
8	Near North	13	.3
9	Edison Park	0	----
10	Norwood Park	2	.05
11	Jefferson Park	2	.05
12	Forest Glen	1	.03
13	North Park	3	.08
14	Albany Park	3	.08
15	Portage Park	3	.08
16	Irving Park	4	.1
17	Dunning	0	----
18	Montclare	0	----
19	Belmont Cragin	3	.08
20	Hermosa	0	----
21	Avondale	1	.03
22	Logan Square	5	.1
23	Humboldt Park	3	.08
24	West Town	7	.2
25	Austin	12	.3
26	West Garfield Park	3	.08
27	East Garfield Park	10	.3
28	Near West Side	13	.3
29	North Lawndale	10	.3
30	South Lawndale	3	.08
31	Lower West Side	5	.1
32	Loop	1	.03
33	Near South Side	7	.2
34	Armour Square	56	1.5
35	Douglas	44	1.2
36	Oakland	56	1.5
37	Fuller Park	60	1.6
38	Grand Boulevard	117	3.1
39	Kenwood	129	3.4
40	Washington Park	84	2.2
41	Hyde Park	345	9.1
42	Woodlawn	641	16.9
43	South Shore	450	11.8
44	Chatham	93	2.5
45	Avalon Park	58	1.5
46	South Chicago	133	3.5
47	Burnside	37	1.0
48	Calumet Heights	31	.8
49	Roseland	88	2.3
50	Pullman	46	1.2
51	South Deering	30	.8
52	East Side	22	.6
53	West Pullman	21	.6
54	Riverdale	22	.6
55	Hegewisch	4	.1
56	Garfield Ridge	8	.2
57	Archer Heights	2	.05
58	Brighton Park	5	.1
59	McKinley Park	1	.03
60	Bridgeport	14	.4
61	New City	48	1.3
62	West Elsdon	1	.03
63	Gage Park	3	.08
64	Clearing	9	.2
65	West Lawn	14	.4
66	Chicago Lawn	34	.9
67	West Englewood	62	1.6
68	Englewood	180	4.8
69	Grand Crossing	143	3.8
70	Ashburn	26	.7
71	Auburn Gresham	90	2.4
72	Beverly	8	.2
73	Washington Heights	45	1.2
74	Mount Greenwood	10	.3
75	Morgan Park	24	.6
	Out of City	315	8.3
	Unknown	2	.05
	Total	3,800	100.4

[1] Rounded to next larger number.

TABLE VII.—*Community Areas Of Residence: Patients Seen In Emergency Rooms of Mercy and Billings*

	Community area (number and name)	Billings	Mercy
23	Humboldt Park	1	---
28	Near West Side	2	1
29	North Lawndale	1	---
30	South Lawndale	1	2
31	Lower West Side	---	2
33	Near South Side	---	4
34	Armour Square	1	8
35	Douglas	---	10
36	Oakland	3	1
37	Fuller Park	1	---
38	Grand Boulevard	6	12
39	Kenwood	4	4
40	Washington Park	4	---
41	Hyde Park	10	---
42	Woodlawn	34	5
43	South Shore	6	2
44	Chatham	6	2
45	Avalon Park	6	---
48	Calumet Heights	2	1
49	Roseland	2	1
50	Pullman	2	---
55	Hegewisch	---	1
56	Garfield Ridge	---	1
57	Archer Heights	1	2

	Community area (number and name	Billings	Mercy
58	Brighton Park	1	---
59	McKinley Park	---	4
60	Bridgeport	1	16
61	New City	1	1
63	Gage Park	---	1
67	West Englewood	3	5
68	Englewood	9	3
69	Grand Crossing	6	4
71	Auburn Gresham	6	2
72	Beverly	1	---
	Out of City	4	4
	Unknown	8	1
	Total	133	100

TABLE VIII.—*Emergency rooms: Distribution of variable for emergency rooms, Mercy and Billings*

Variable	Mercy Number	Billings Number	Percent
Age:			
0 to 16 years	36	35	26.3
17 to 40 years	43	63	47.4
41 to 64 years	17	27	20.3
65 years and older	4	5	3.7
Unknown	0	3	2.3
Total	100	133	100
Sex:			
Male	50	55	41.3
Female	50	78	58.6
Total	100	133	99.9
Race:			
White	23	16	12
Negro	35	117	87.9
Other	1	0	---
Unknown	41	0	---
Total	100	133	99.9
Source of referral:			
Friend or relative	56	67	50.3
Self	15	48	36.1
Police or fire department.	29	11	8.3
Unknown	0	7	5.3
Total	100	133	100
Time of arrival at Emergency Room			
9 a.m. to 12 noon	10	22	16.5
12 noon to 5 p.m.	27	25	18.8
5 p.m. to 12 midnight	42	35	26.3
Midnight to 9 a.m.	19	27	20.3
Unknown	2	24	18
Total	100	133	99.9
Diagnoses:			
General medical problems.	57	77	57.9
Lacerations	24	20	15
Fever	8	3	2.3
Broken Bones	3	4	3
Gunshot wound	1	1	.7
Dermatology	1	1	.7
Psychiatric problem	0	3	2.3
Drug reaction accident	0	1	7
Rape	0	1	.7
Removal of sutures	0	2	1.5
Comatose	1	0	---
Obstetrics and gynecology.	3	0	---
Dental	1	0	---
Unknown	1	20	15
Total	100	133	99.8
Disposition:			
Sent home	49	68	51.1
Referred to these hospital clinics.	30	24	18
Referred to other hospital or M.D.	13	15	11.3
Admitted to hospital	3	13	9.8
Left without being seen.	3	3	2.3
Left against advice	0	2	1.5
Unknown	2	8	6
Total	100	133	100
Source of payment for medical care:			
Insurance	59		
Self	19		
Public funds	15		
Medicare	4		
Unknown	3		
Total	100		

Section IV. The Students

Participants in the Student Health Project during the summer of 1968 included those in college, in postgraduate study in the health professions, other graduate study and high school students. For ease in reporting, the college and graduate students will be referred to as the health science students; the high school students will be referred to as interns.

THE HEALTH SCIENCE STUDENTS

One hundred and twenty four health science students participated in the summer project. This section will define some selected characteristics of the students, their backgrounds and some of their views to provide the reader with a few insights into the kinds of students who elected to participate in the summer project.

Some of these characteristics are self-explanatory and no comments are offered:

Characteristic:	*Percent of 124 students*
Characteristic:	
Sex:	
Male	56
Female	44
Total	100
Age (in years):	
Under 21	11
21 to 23	59
24 to 26	23
27 and older	7
Total	100
Race:	
White	83
Black	17
Total	100

Almost 60 percent of the students were preparing for careers in the health professions. Another 2 percent were in premedical undergraduate programs. Five percent were in social work schools, some of whom will probably enter the field of medical social work. The remaining one-third of the students were distributed through a variety of related fields.

Field of study:	*Percent of 124 students*
Health professions	59
Medicine (38 percent)	
Nursing (14 percent)	
Dentistry (2 percent)	
Allied health (5 percent)	
Law	10
Social sciences	9
Humanities	6
Social work	5
Other professions	4
Premedical programs	2
Natural sciences	1
Not specified	4
Total	100

While the majority of the students attended colleges and universities located in Chicago, a substantial number (36 percent) came from schools around the country. That distribution is as follows:

Locations of colleges or universities:	*Percent of 124 students*
Chicago	55
University of Chicago (18 percent)	
University of Illinois (16 percent)	
Loyola University (10 percent)	
Chicago Wesley Memorial Hospital (School of Nursing) (3 percent)	
Roosevelt University (2 percent)	
Northwestern University (1 percent)	
Chicago College of Osteopathy (1 percent)	
Kent College of Law (1 percent)	
Other Chicago colleges (2 percent)	
Other Illinois	2
Other States and areas	36
California (6 percent)	
Michigan (4 percent)	
New York (6 percent)	
Pennsylvania (4 percent)	
Tennessee (3 percent)	
Missouri (2 percent)	
Utah (2 percent)	
District of Columbia (1 percent)	
All other States (8 percent)	
Not presently in school	4
Not specified	4
Total	101 [1]

[1] Due to rounding.

The students were queried as to their parents' religious preferences and their families' annual income. A substantial number of them did not respond to either question even though most of them had responded with some degree of faithfulness to a number of questionnaires. Whether they specifically chose not to answer these two questions is not known.

Religious preference:	*Percent of 124 parents*
Protestant	30
Jewish	24
Catholic	17
Other preference [1]	7
No answer	22
Total	100

[1] Includes those whose parents preferences differ for each parent, as well as those with other or no religious preferences.

While it is not possible to determine the affluence of the students' homes, since neither the size of their families nor the nature of their financial obligations are known, a cursory review indicates that a majority were from homes where the family incomes currently are above those of the United States population as a whole. The following table presents the comparison between incomes of the students' families and income of U.S. families.

Annual income brackets	*Percent families of students in bracket* [1]	*Percent U.S. families in bracket*
Under $5,000	7	33
$5,000 to $9,999	22	42
$10,000 to $14,999	30	17
$15,000 and over	41	8
Total	100	100

[1] 98 students answered question, 26 did not.

The differences between the students' family incomes and U.S. families may be even more marked at the upper brackets. Data were not avaiable for U.S. families in specific categories above $20,000 and $25,000 respectively. However, this information was available for the students' families. Of the 41 percent whose incomes were in a range above 15,000 per year, 16 percent were between 15,000 and $19,999, 14 percent were between $20,000 and $25,000 and 10 percent had incomes over $25,000 per year. Twenty percent of the students did not respond to this question either from lack of knowledge or perhaps a refusal to divulge this information just as a large percent did not answer queries about religious preference. However for the 80 percent who did answer, it would appear that the students in the summer project could generally be considered to come from relatively affluent backgrounds.

In questionnaires administered to the health science students, a number of queries probed their attitudes on a variety of subjects related to health and health issues. They were also asked to describe their reasons for participating in the summer project and what, if anything, they learned from the summer.

Only 87 of the health science students responded to the queries so that the data to be presented pertain to those students who responded and represent approximately 70 percent of the participants in the summer project.

The reasons for their decision to participate in the summer project are presented first, based on eight suggested reasons for them to rank in order of importance to them. A point system was designed and their responses to this question were tabulated on that basis. According to the assignment of points, the following are the reasons in order of primary importance as to why the respondents participated in the summer project.

TABLE I.—*Ranking of possible reasons (or goals) for participating in the summer project according to most important reason*

Goals
1. To learn about health problems of the poor and the delivery of health services to them.
2. To help poor people get better medical care and medical services.
3. To help initiate and continue political action for social change in a poverty area.
4. To acquire a better understanding of welfare problems.
5. To earn money.
6. To work in Chicago.
7. To work with other health professionals.
8. To be with friends.

A desire to learn about the health problems of the poor was by far the most important reason for student participation. The point dif-

ferential between that as the first reason and the next three reasons was substantial. Reasons two, three, and four, helping poor people get better medical care, helping initiate action for change and acquiring a better understanding of welfare problems were fairly closely clustered as the next major reasons for participation. The last four reasons were of far less importance and were relatively closely clustered.

The students were asked whether they had learned much, some little, or nothing about 16 variables as a result of their summer experience.

The responses to this question are shown on table II, with the items eliciting the greatest degree of positive response listed first.

More respondents said they learned a good or great deal about the quantity and quality of health care and housing conditions of the poor, 66, 61, and 58 percent respectively, than they learned about any other of the listed conditions. In fact, only 16, 13, and 15 percent, respectively learned little or nothing about these factors.

Respondents also felt they learned a significant amount concerning organization of medical care services, professional practices and community attitudes toward health care. For example, only 30 percent of those who answered the ninth ranked item—innovations in health care for the urban poor—indicated they learned little or nothing about it.

When specific health problems of the poor and their attempts to deal with them are considered, the percentage of respondents who learned a good deal or a great deal declines rapidly. Only 28 and 22 percent, respectively, felt they learned a good deal about lead poisoning and nonprofessional health carers. Only 13 percent indicated they learned much about malnutrition among the urban poor and only 12 percent learned a good deal about folk medicine among the urban poor. The students felt they learned little or nothing about mental illness, heart disease, and cancer respectively. It is probable that the small percentage of students who learned a good deal about these particular disease entities worked at sites whose major interest was in these areas. Learning more about the health problems of the poor and delivery of health services to them was ranked as the most important reason for participation in the summer project and the data indicates that this goal was accomplished.

The fact that they learned little or nothing about specific disease entities (mental illness, heart disease, and cancer) is probably to be ex-

Rank	Item	Percent of respondents who learned—			Total number equals 87
		A good or great deal	Some	Little or nothing	
1	The quantity of health care received by the poor	66	18	16	87
2	The quality of health care received by the poor	61	26	13	82
3	Housing conditions of the urban poor	58	27	15	78
4	The organization of health services for the poor in an urban setting.	56	22	22	77
5	What professional practice is like in poverty areas	49	24	27	86
6	Organization and problems of city hospitals	48	19	33	86
7	Community attitudes toward health problems	46	30	24	83
8	Community groups concerned with health issues	43	31	26	81
9	New innovations in health care for the urban poor	39	31	30	81
10	Lead poisoning among the urban poor	28	23	44	83
11	New health careers for nonprofessionals	22	29	49	87
12	Malnutrition among the urban poor	13	21	66	77
13	Folk medicine among the urban poor	12	20	68	80
14	Mental illness among the urban poor	2	28	70	82
15	Heart disease and stroke among the urban poor	1	11	88	76
16	Cancer among the poor	1	4	95	74

pected. It would seem unlikely that health science students, most of whom spend their entire academic year studying the etiology and effect of pathology would become involved in this experience—a community health project—for that purpose.

Answers to the question, "To what extent was your involvement a learning experience?" provided the information that 80 percent of the respondents felt they learned a great deal this summer. Another 10 percent said it was something of an educational experience for them. Only 10 percent felt they learned little or nothing as a result of their participation in the summer project.

The impact of their experience relative to their career objectives was probed. They were asked, "To what extent do you think this summer's experience will relate to your career objective?" More than 90 percent said a great deal or some relationship existed between their summer's experience and their career objectives. Only 7 percent felt there was little or no relationship.

Only 31 percent responded positively when asked, "To what extent did your work increase the health consciousness of the community in which you worked?" About the same percentage (34) felt that the community in which they worked during the summer had benefited some or a great deal from their presence. This correlates with their responses to the question, "To what extent were you successful in achieving your objectives this summer?" In this case, only half of the students felt they had been successful in achieving their summer's objectives. Since second and third in importance among their goals were to help poor people get better medical care and to help initiate action for change in poverty areas, it would seem that they felt the summer had fallen short of their hopes for accomplishing these goals.

Six alternatives were given them as specific ways of improving the health status of poor people. They were asked to rank these in order of what they considered the most effective way of improving such services. Points were again assigned and the following is their ranking of effective plans.

TABLE III.—*Specific plans to improve health status of the poor*

1. Remove all economic barriers to health and medical services.
2. Create more medical care centers in poor neighborhoods—in convenient locations.
3. Improve the quality of health care actually given to poor people.
4. Increase the employability of poor people—provide more jobs for them.
5. Improve housing conditions for the poor.
6. Raise the general level of education of poor people.

Actually there was a small point difference between the items they ranked first and second as most effective plans for improving health status. The last four items were clustered not far behind the first two ways they considered most effective for changing the health status of the poor.

TABLE IV.—

Community priorities (as the students perceived them):

1. Increased employment opportunities.
2. Improved housing.
3. Development of ethnic power.
4. Enlargement of educational opportunities.
5. Liberalization of health care.

The first four items were relatively closely clustered in point values but the fifth item liberalization of health care, was considerably behind the first four in the view the students had of community priorities.

In summary, the health science students were mostly white, from affluent homes, and at an advanced level of education. They appeared to be idealistic, enthusiastic and eager to play a constructive role in assisting those they considered less privileged than themselves and in learning more about them.

The summer's experience did not meet the goals of some. For others, there was a feeling of accomplishment. For almost all of them—the summer had been a valuable educational experience. For many, it may have a substantial influence on their lifetime goals.

THE HIGH SCHOOL INTERNS

There were 74 high school students or 1968 high school graduates in the summer project. The information presented in the following is based on questionnaires which they filled out.

Characteristics of the high school interns are almost completely the reverse of those described for the health science students.

The age distribution of the students was different, obviously. Perhaps, some of the difficulties that existed can be attributed, in part, to a "generation gap" between teenagers and students in their mid-twenties. This thought might provide a moment of amusement to those past 30 years of age.

Age (in years):	*Percent of high school students*
14	1
15	9
16	41
17	28
18	11
19	6
20	3
Total	99[1]

[1] Due to rounding.

There were more females among the high school interns and fewer males, almost exactly the reverse of the ratio for the health science students.

Sex:	*Percent of high school students*
Male	44
Female	56
Total	100

Racial and ethnic background were completely different as well.

Race or ethnic background:	*Percent of high school students*
Negro	86
White	5
Spanish-speaking	6
American Indian	3
	100

While 83 percent of the health science students were white, 86 percent of the interns were black. The differences in sex, race, and age surely must have contributed some elements to the difficulties where students encountered them in their working relationships. Probably, the most important single factor influencing difficulties was the racial difference. However, the high school interns who responded to questions concerning their feelings about the health science students on their individual projects showed highly selective reactions to the other students. In a few cases, particular health science students were characterized as racist by the interns. In a larger number of cases, the interns were friendly but critical of their health science coworkers. In the majority of cases the interns indicated respect and affection for the health science students with whom they personally worked, both black and white. Since responses to the questionnaires were confidential, the high school students probably stated their opinions honestly.

It is worth discussing these relationships further since there were references in the text of the students' reports which highlighted difficulties in specific areas. The following excerpts from black interns' questionnaires are quoted to describe their feelings about the health science students in several instances.

Two of the questions asked were: (1) What did the intern like best about the health science student(s) with whom he worked, and (2) what did the intern like least about their colleagues. The students comments below are grouped by interns who like their health science partners; interns who liked them but were critical of them as well; and interns who disliked their health science partners, sometimes intensely. Each set of quotations is from a single intern's response:

Liked most: "Her sincerity in willing to do something about the infant mortality cases in [name of community]. Her sense of responsibility to do the job well and on time. Her hope to keep the project going rather than stop at the end of the weeks of payable work."

Liked least: "Nothing—And believe me I'd tell."

Liked most: "He was a very understanding person. Treats you with respect. He doesn't act like he's any better than you. He's alright."

Liked least: "Nothing."

Liked most: "She was swell to get along with, a good worker and no problems arose between us. We worked practically hand in hand."

Liked least: "No comment because there is nothing I didn't like about her.

Liked most: "We all worked together as a group. One didn't go any higher than the other. Each of us did the same work."

Liked least: "Everything about the health science students was just wonderful. We got along together, ate together and fought together when the time came."

The remarks of interns who liked their health science students but were critical of them as well follow:

Liked most: "Their pleasing personalities, honest opinions, willingness, helpfulness, honesty, and most of all, consideration for others."

Liked least: "I think the whites should learn to be more willing and ready to learn from the blacks about their problems and less domineering and supervising in such instances. Take orders instead of giving them."

Liked most: "At the [name of site] the H.S.S. were really involved and I feel that they became aware of the real problems."

Liked least: "There was one I really didn't care for and he happened to be black. He would call me in the middle of the night to find out what I had done during the day."

Liked most: "Some of the health science students were ready, the others weren't worth talking about. Some were willing to help, the others just came to work."

Liked least: "Some were lazy, self-concerned, helpless, hopeless and dirty."

These were the hostile comments:

Liked most: "I only liked one of my three health students and that one was black. The reason why I liked him is because he is a very nice and considerate person with a wonderful personality in my eye sight."

Liked least: "One calling us niggers and the way they took leadership in hand and pretended that we were still slaves."

Liked most: "Nothing!"

Liked least: "We wanted to work in the black communities where help is really needed. They (H.S.S.) worked in [name of area] and on the north side. This proved to me that they didn't care about the health care of black people and that they wouldn't make good doctors. Because doctors are concerned about the health care of human beings BLACK OR WHITE." [Emphasis the student's]

Liked most: "She helped me to understand the white race and all their little tricks better."

Liked least: (1) She was a spoiled brat that always wanted her way. (2) She thought that she was actually doing something in our community. (3) She also was a terrible flirt. I don't have any more room to finish."

Finally, there was an amusingly ambivalent response.

Liked most: "I liked his ability to see things from all sides before making a judgment or decision. His fairness was also appreciated by me."

Liked least: "Personally, I couldn't stand him though I think he believes I like him. There was something about him, which I haven't discovered yet that rubbed me the wrong way. We got along beautifully though."

And a terse response:

Liked most: "Transportation."

Liked least: "Temper."

And one different kind of criticism:

Liked most: "They were all right, except one in [name of community]."

Liked least: "He was always thinking."

The proportion of friendly, indeed warm and affectionate, comments was much higher than the critical or hostile ones. Therefore, while the race issue loomed large in some instances, whether race was really the issue may be open

to question, although it undoubtedly played a part. Rather, the human condition is present and the individual personalities of the participants is highlighted in the interns' comments. This may have been the factor which was most important in any difficulties which existed between the groups.

The differences between family income of high school students and health science students also are great. While 70 percent of the health science students came from families whose incomes were over $10,000 per year only 10 percent of the interns' families were in this category. And at the other end, 38 percent of the interns' families had incomes below $5,000 per year while only 7 percent of the health science students' family incomes were in this bracket.

There were also interesting differences between income of U.S. families as a whole and families of the interns. These are as follows:

Annual income brackets	*Percent families of black interns in bracket* [1]	*Percent U.S. families* [1] *in bracket*
Less than $3,000	11	17
$3,000 to $4,999	27	16
$5,000 to $9,999	52	42
Over $10,000	10	25
	100	100

[1] 60 students answered question, 14 did not.

Since 86 percent of the students were black, family income data for only the Negro interns was compared with family income data for nonwhite U.S. families and again interesting differences are present. The comparison is as follow:

Annual income brackets	*Percent families of black interns in bracket* [1]	*Percent non-white U.S. families in bracket*
Less than $3,000	10	37.3
$3,000 to $4,999	26	25.2
$5,000 to $9,999	56	29.2
Over $10,000	8	8.3
	100	100.0

[1] 52 students answered question, 2 did not.

It would appear that the interns' family incomes were not representative of nonwhite families in the United States as a whole. While it can hardly be said that an income between $5,000 and $10,000 per year is affluent, it seems that black high school students in the summer project generally were somewhat better off than their peers around the country.

The last characteristic which will be mentioned is that of the career aspirations of the interns. Almost all of them have career goals that require education or vocational training beyond the high school level. While their goals are undoubtedly subject to change, perhaps even a number of times, they worth describing here. First the grade-level distribution of the interns indicates that more than 80 percent of the respondents are new in the junior and senior years of high school and 10 percent had been accepted at colleges or junior colleges for the fall. At this stage in their educational preparation they are probably thinking seriously about their future careers.

Over half of the respondents (56 percent) said they intended to go on to college and another 14 percent said they planned to go to junior college. While some students were undecided or did not respond to the question, only one student wrote that he did not plan to continue his education beyond high school. Almost all of them planning for higher education stated they would have to receive financial aid or would have to work to finance a college education. Only three of the interns indicated that their parents would be responsible for financing them through college.

A first career choice was stated by 54 interns while the remaining nine who filled out the questionnaires were either undecided or did not specify a career interest. The choices of the 54 are as follows:

First Career Choice:	*Percent of students*
Health professions	46
Medicine (24 percent)	
Nursing (13 percent)	
Allied health (9 percent)	
Teaching/education	15
Social work	9
Computer science technology	5
Other professions [1]	13
Other careers [2]	12
Total	100

[1] Other professions includes law, engineering, sociology, etc.
[2] Other careers includes military, business, forestry, football, etc.

As is apparent, almost half of the students said they planned to pursue a health career and half of these indicated a desire to become physicians. What effect their summer experience had upon their career choices is not possible to guess since comparable information was not sought prior to the start of the summer project.

In summary, the high school interns were mostly black, from lower middle income homes with high aspirations for the future. Their questionnaire responses showed them to be idealistic, enthusiastic, and eager to play a constructive role in helping themselves, and their people, to achieve status and dignity in society. That their summer's experience had an impact upon them cannot be stated with any certainty, however, a number of them plan to continue work on projects started this summer. Their exposure to health issues and health system has made them more aware of the important role health plays in their everday lives and in the lives of the communities in which they reside.

Section V. LIST OF PARTICIPANTS AND SITES

PARTICIPANTS

Health Science Students

Stanley Aeschleman
Patricia Bailey
Irene Baker
Sara Joan Bales
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Susan Bennett
Jack Berger
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Walter Lowe
Patricia A. Lowery
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Irwin Miller
Ellyn Millman
Margo A. Montry
Dean Morgan
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Ralph McMurry
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Dean Lee Overman
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Pamela Zumwalt

High School Interns

Emillo Acevedo
Danny Anderson
Jessica Anderson
Willie Barney
Joseph Brown
Pamela Brown
Midacrito Cano
Betha Carr
Maryln Carter
Yvonne Christman
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James Easter
Lewis Edwards
Joe Lopez Enderle
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Dan King
Lucy Lane
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William McNary
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Susan Peterson
Lola Porter
Gwendolyn Ramsey
Mavies Randle
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Katherine Sawallisch
Bernard Seals
Francine Shane
Gwendolyn Shane
Naomi Shine
Darryl Speer
Rose Marie Steward
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Alfred Taylor
Lucius Taylor
Paul Taylor
Daniel Thompson
Richard Tinsley
Debra Wash
Drexel Weathersby
Veronica Weathersby
Janet Williams
Sandra Williams
Ernest Winkfield
Valerie J. Woods
Deborah Young

SITES

Abraham Lincoln Center
700 East Oakwood Boulevard
Preceptor: Mrs. Hilton

American Indian Center
1630 West Wilson
Preceptor: Tony Madjekoy

Benton House Neighborhood Resources Center (Mexican Outpost)
2624 South Normal
Preceptor: Mr. Dick Hall (Director)

Black Women's Committee
4300 Cottage Grove
Preceptor: Jackie Robbins

Casa Central
40 North Ashland
Preceptor: Reverend Alvarez

Chicago Board of Health
Chicago Civic Center
Preceptor: Dr. Stamler

Concerned Citizens of Lincoln Park
2512 North Lincoln Avenue
Preceptor: Sherry Levine

Cook County Hospital Out-Patient Clinic
Preceptor: Dr. Bernstein

Dearborn Homes-Booth House
2961 South Dearborn
Preceptor: Mr. Cotten

Drug-Abuse Program (Operating out of Association House)
2150 West North Avenue
Preceptor: Mary Williams

Englewood Action Committee of the Englewood Civic Organization
140 West 62d Street
Preceptor: Rev. Richard Lawrence (of the Action Committee), Mrs. June Dolnick (of Englewood Citizens Housing Committee)

Englewood Clinic
140 West 62d Street
Preceptor: Doug Peterson (Rev. Richard Lawrence President of Englewood Action Committee)

Englewood Mental Health Center (Board of Health)
852 West 63d Street
Preceptor: Mrs. Adele Levine

Erie Neighborhood House
1347 West Erie Street
Perceptor: Evelyn Lyman, R.N.

Garfield Civic Association
5600 South Racine
Preceptor: Mrs. Rita Skeffinton

(East) Garfield Park Mental Health Clinic
4458 West Madison
Preceptor: Mrs. Moon

Greater Lawn Family Care Center
2701 West 68th Street
Preceptor: Dr. Jim Reese (Director)

Hospital Planning Council
79 West Monroe
Preceptor: Pierre DeVise

Latin American Defense Organization (LADO)
1306 North Western
Preceptor: Obed Lopez

Lawndale Association for Social Health (LASH)
3346 West Roosevelt
Preceptor: Bob Taylor, Joe McDonald, Dr. Eric Kast

Marcy Center
1539 South Springfield
Preceptor: Mrs. Betty Dobbins

Martin Luther King Memorial Clinic
3312 Grenshaw
Preceptor: Dr. Snyder

Medical Center YMCA
2067 West Roosevelt
Preceptor: Hosea Lindsay

Michael Reese Hospital
29th and Ellis
Preceptor: Dr. M. Creditor

Neighborhood Service Center (Howell House)
1831 South Racine
Preceptor: Jose Morales

Olivet Community Church
1443 North Cleveland
Preceptor: Charles Marz

Presbyterian—St. Luke's Hospital
Preceptor: Bruce Douglas, D.D.S.

Provident Hospital
426 East 51st Street
Preceptor: Mrs. Cobb, Director of Volunteers

Robert Taylor Health Clinic
Ida Noyes Hall, University of Chicago

St. Bernard's Hospital
6337 South Harvard
Preceptor: Sr. M. Shephard, Supervisor of Emergency and O.P.D.

St. Leonard's House
2100 West Warren
Preceptor: Earl Durham

South Lynne Community Council
1737 West 63d Street
Preceptor: Mrs. Donna Scheidt (Housing Chairman) Rev. James Scorgie (Youth Chairman)

South Lynne Day Camp, Thoburn Methodist Church
1708 West 64th Street
Preceptor: Rev. James Scorgie

Tri-Faith Employment
1361 West Wilson
Preceptor: Chuck Geary

Trumball Park Community Center
10530 South Oglesby
Preceptor: Mrs. Tikalsky
United People
1354 West Wilson
Preceptor: Rev. George Morey
Woodlawn Child Care Center
936 East 63d Street
Preceptor: Dr. Madden
Woodlawn Hospital
61st and Drexel
Preceptor: Mr. Jacobs-Hospital Administrator

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